HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE
PREPARED BY THE DEPARTMENT OF HEALTH
AND SOCIAL SECURITY

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CONTENTS

	page
Hospitals in Great Britain	59
Hospitals in other countries	59
Planning, design and construction	62
Hospital design	62
Design of individual general hospitals	63
Extensions and reconstructions	63
Design of special departments	63
Estate management	63
Engineering services	63
Installations in general	63
Electrical installations and equipment	64
Artificial lighting	64
Communication systems	64
Transport in general	65
Heating	65
Ventilation and air-conditioning	65
Maintenance of buildings and equipment	66
Equipment, fittings, furniture	66
Floors and floor coverings	66
Equipment generally	66
Medical equipment	66
Electronic equipment	66
Staff generally	66
Staff complements	66
Recruitment and manpower	66
Staff management	67
Staff relations	67
Staff training	67
Staff welfare	68
Special classes of staff	68
Administrative and clerical staff	68
Medical staff	69
Nursing staff	71
Other professional and technical staff	73
Organization and administration	73
Economics of hospital management	75
Bed occupancy, economic use of beds	76
Electronic data processing	77
Information systems	77
Medical records	78
Hospital statistics	79
Legal aspects of hospital administration	79
Finance and accounting	80
Costs	80
Finance	81
Hospital accounting	81
Supplies and stores	82
Supplies	82
Economic use of supplies, disposables	82
Catering, dietetics, kitchens	82
Hospital catering	82
Dietetics in the hospital	85
Laundries and linen service	85
Hospital linen and textiles	85
Hospital domestic management	86
Hygiene in the hospital	86
Hospital infections	86
Prevention and control	86
Hygiene in the operating theatre	87
Sterilization	87
Safety measures	88
Planning for mass emergencies	88
Radiation hazards	88
The patient	89
Welfare of the patient	89
Voluntary service, voluntary workers	89
Hospital chaplains	90
Transport of patients	90
Terminal care	90
Hospital care	90
Home care, after-care	92
Special departments	93
Wards	93
Operating suites	93
Anaesthesia	93
Pharmacy	93
Laboratories	94
Blood transfusion department	94
Milk banks	95
Diagnostic X-ray department	96
Rehabilitation	97
Physiotherapy department	97
Departments for special therapy	97
Intensive care units	98
Special hospitals and units	99
Out-patient	99
Casualty and accident	99
Day hospitals	101
Infectious diseases and isolation	101
Children	101
Geriatrics and long-stay	103
Cancer	104
Neurology and neurosurgery	105
Cardiology	105
Venereal disease	106
Surgery	106
Maternity	108
Gynaecology	109
Psychiatry	110
Author index	v
Addresses of publications	vi

HOSPITAL ABSTRACTS

Vol. 19 February 1979 No. 2

HOSPITALS IN GREAT BRITAIN

156. WHILE, A. E. **The vital role of the cottage-community hospital.** *Journal of the Royal College of General Practitioners*, London, 1978, Aug., vol. 28, no. 193, pp. 485-491.

The history of general practitioner hospitals is reviewed and a case made for their retention and extension. Among the advantages they provide are: a local service for patients; less expensive hospital care than is possible in a district general hospital; less travelling expenses for patients; valuable post-graduate education for doctors; and improvement of general practitioner morale.

157. MACGILLIVRAY, B. **London undergraduate teaching hospitals.** *Journal of the Royal Society of Medicine*, London, 1978, Sept., vol. 71, no. 9, pp. 637-643.

The author describes how the re-organization of the National Health Service in 1974 has affected both the medical schools and the service to patients in undergraduate teaching hospitals, particularly in London. Through its teaching hospitals, colleges and institutes, London provides a concentration of medical excellence which serves the whole country. Dividing London into regions is not conducive to the development of resources in teaching hospitals which, while providing district care, also offer a wide range of specialties to a far wider area. The teaching and research carried out in teaching hospitals is generally beneficial to the health service as a whole. The London medical schools produced a third of Britain's medical graduates in 1977 and the author discusses current teaching practice. The present proposals of the Resource Allocation Working Party would severely reduce the work of London's teaching hospitals, thereby limiting a major national resource.

HOSPITALS IN OTHER COUNTRIES

158. MONTEGRIFFO, C. **History of medicine in Gibraltar.** *British Medical Journal*, London, Aug. 19, vol. ii, pp. 552-555.

Before a well-equipped Naval Hospital was built in Gibraltar in 1740, the island was served by the Hospital of St. John of God, founded by Juan Mateos in 1567. In 1903 a military hospital was built which, under either military or naval control, has taken care of service staff ever since. In 1800 the first major epidemic of yellow fever hit Gibraltar, killing half the population by 1805 and, despite Gibraltar's numerous sieges, disease rather than warfare continued to be the main threat to life until well into the nineteenth century. A civilian hospital was opened in 1816. For 150 years after the founding of this hospital, hospital medicine was state supported but private general practice was lucrative for doctors qualified in Britain, Spain and France. In 1880, the civilian hospital was enlarged and became the Colonial Hospital, controlled by a new state medical department. It was re-named St. Bernard's in the 1960s. The

King George V Memorial Hospital was opened in 1939 to treat tuberculosis and is now a psychiatric hospital. The present pattern of medical service and financing in Gibraltar is similar to that operating in the United Kingdom.

159. GASSILLOUD, B. L'hospitalisation en Europe (1 ère partie). **[Hospitals in Europe (part 1).]** *Gestions Hospitalières*, Mantes, 1978, Aug./Sept., no. 178, pp. 603-613.

This comparison of health expenditure and hospital organization in six European countries—France, Italy, Sweden, Great Britain, West Germany, and Belgium—takes the form of a commentary on a series of six tables which give the total number of beds, total number of acute beds, number of beds per 1,000 population, average bed occupancy rate, distribution between private and public sectors, total number of hospitals, and average size of hospitals. This is followed by an analysis, accompanied by a further six tables, of the methods of financing the NHS in Great Britain and the Swedish Health Service.

160. ERRAHMANI, E. Les équipements hospitaliers en Île-de-France. **[Hospital services in the Île-de-France.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Aug./Sept., vol. 33, nos. 395/396, pp. 47-54.

A description is given of the hospital facilities in the Île-de-France region, which includes the City of Paris and its inner and outer rings of suburbs. Data are presented concerning the total number of beds, the geographic distribution of facilities, the distribution of these between private and public sectors, use and activity of hospitals, provision of new hospitals, and variations within the region, and in particular the disparity between central Paris and the suburbs. The objectives of regional policy are to redistribute facilities more equitably while maintaining quantity and improving quality, to achieve a proper balance between public and private hospitals, and to increase the emphasis on out-patient treatment. The tools for this policy are the health map, epidemiological studies, and a master plan.

161. ERRAHMANI, E. L'Observatoire Régional de Santé: un instrument d'études au service de la région d'Île-de-France. **[Regional Health Observatory: a study centre for the Île-de-France Region.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Aug./Sept., vol. 33, nos. 395/396, pp. 44-46.

This is an account of the work of the Observatory for the Île-de-France region. It is a statistical research unit which provides a permanent inventory of medical services in the region. The unit also carries out demographic and epidemiological surveys and studies, in order to provide information on present and future needs and to supply data for the health map. The unit's publications up to date include a survey of nurseries, general hospital bed facilities by specialty in 1973, and a health map relating to haemodialysis of chronic renal insufficiency in adults.

162. GÜNTHER, O. A kórházak müködésének jövöbeni rendszere. **[Future methods of organizing hospitals.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1978, June, vol. 16, no. 2, pp. 143-148.

The Medical Director of Dresden District Hospital discusses some current methods

of developing the internal structure of hospitals. The development of medical science and technology shows that the organizational structure of hospitals is determined more and more by modern mutually dependent work operations, and less and less by traditional medical faculties. However, centralization has not yet changed the administrative and organizational system of hospitals, and certain administrative levels do not always correspond to the physical layout of the structure.

163. AUSTRALIA. HOSPITALS AND HEALTH SERVICES COMMISSION. **A report on hospitals in Australia.** Canberra, Australian Government Publishing Service, 1974, xix, 278pp. $3.60

The Hospitals and Health Services Commission was established by the Australian Government to ascertain the health care needs of the Australian community and to make recommendations in respect of these needs. After analyzing the existing situation, the report treats nursing homes, mental health institutions and hospitals separately, giving a survey of present hospital services and plans for improvement. Other chapters cover: a philosophy of health care organization; programme objectives; and recommendations on capital funding. Twenty-two appendices cover many aspects of hospital and health services, including: Interim Regional Boundaries proposed by the Department of Urban and Regional Development; administration of the hospital system; hospital staffing; costs and performance of the hospital system; and the efficient planning of hospitals. An atlas section shows the location of private and public hospitals, mental hospitals, service hospitals, teaching hospitals and nursing homes.

164. L'hôpital Saint-Jean à Bruges. **[St. John's Hospital, Bruges.]** *Hôpital Belge*, Bruxelles, Sept./Oct., vol. 21, no. 135, pp. 29-39.

A brief description, with 12 photographs, is given of the new 918-bed hospital built to the north east of the city, which replaces the 800-year-old St. John's Hospital in the centre of Bruges. The new hospital comprises a 14-storey block, with the wards on the upper seven floors, and the neurology, psychiatry, rehabilitation, and intensive care units on the lower floors, and a seven-storey medico-technical block, which houses the rest of the 42 clinics and the technical services. There are 14 specialist operating theatres in addition to the main suite for general surgery. The hospital employs 110 doctors and 1,100 other staff.

165. KESSLER, M. S., FRENZEN, P. D. and BERGMANN, R. L. **Selected community hospital indicators, 1976.** Chicago, American Hospital Association, 1978, iii, 65pp. $6.25

This book presents 48 common indicators describing the use, operation and demographic and economic environment of community hospitals in the United States. The data were derived from a variety of sources and are compiled from aggregated data for entire states and geographic areas, and represent average findings for a given region. The five parts consider: census divisions; states; standard consolidated statistical areas; non-metropolitan and metropolitan areas; and state rankings. An explanation of the terms, formulas for calculations and a list of sources of data are included.

166. WALLACE, S. D., editor. **Nursing home administration: the administrator's role; current topics, conflicts and challenges.** New York, Futura, 1974, xv, 235pp. £8.70

This book presents a review of the organization of a nursing home in the United States. It is in three sections: (i) the psychology of administration; (ii) the influence of the general public and the government; and (iii) death and euthanasia. The first section considers: the attitudes of administrators; patient psychology; sex and the aged; family guilt; personal psychology; unions; ownership; and public relations. Section 2 considers the effect of legislation upon nursing homes; licensure; inspections; cost control; and reimbursement. A glossary of terms is included. Three appendices present a profile of patients; distribution of private and public health expenditures; and facilities and beds analyzed by types of control.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract Nos. 199, 200, 208, 209

HOSPITAL DESIGN

167. **Interior and exterior environments co-ordinated and contrasted in two projects.** *Hospitals*, Chicago, 1978, Aug. 16, vol. 52, no. 16, pp. 38, 40, 42.

The relationships, differences and similarities of interior spaces to each other and to the exterior environment have been emphasized in the two facilities discussed here. The 14th floor of the Mayo Clinic, Rochester, Minn., accommodates the orthopaedic department, a pain clinic, an area for pre-anaesthesia medical evaluations, and space for expansion and change within each department. Because the floor is highly sub-divided and window areas are sparse compared with the enclosed interior areas, the design incorporates features that facilitate circulation, optimize use of windows and exterior views, and provide a sense of light and openness. Houlton (Maine) Regional Hospital is in a corner of the site that is framed by forest on three sides. To accommodate the great difference between summer and winter temperatures in the area, the building incorporates several design features that are both energy-efficient and aesthetic. The exterior walls have two-inch styrofoam insulation placed on the outside facade. There are many small windows, skylights, mirrors and glass partitions within the building. Those features and others, such as mezzanines and courtyards, help to emphasize connections and relationships among different areas, floors and departments of the hospital. Six colour photographs are included.

168. SHEARER, A. **A tolerable version of the old institutional pattern.** *Design for Special Needs*, London, 1978, Jan./April, no. 15, pp. 19-22.

Despite expressed intentions of both improving hospitals for the mentally handicapped and running them down by providing alternative accommodation in the community, hospitals are still the major resource for people with mental handicaps and many are still not up to desired standards. South Ockendon Hospital has reduced its number of beds from 1,000 to 750 and hopes to reach its optimum of 500 within a decade. To cater for this number it has embarked upon a policy of upgrading existing provision—15

'semi-detached' villas with 10 people living on each side carved out of some large buildings, and less dramatic remodelling for others. The cost of each major conversion, at current rates, is £250,000. The first of the major conversions, a children's villa, is now complete; details are given of the changes made. Future plans are discussed briefly.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See Abstract Nos. 164, 167

EXTENSIONS AND RECONSTRUCTIONS

See Abstract No. 169

DESIGN OF SPECIAL DEPARTMENTS

See Abstract No. 311

ESTATE MANAGEMENT

169. RODGERS, A. M. and DREDGE, D. S. **Practical examples and data for upgrading buildings in the health estate.** *Hospital Engineering*, London, 1978, Aug., vol. 32, no. 6, pp. 6-10.

Lack of resources and severe cut-backs in capital expenditure have enforced reconsideration of needs, building stock and existing facilities. Based on their experience in the upgrading of buildings, the authors have developed statements and procedures particularly relevant to small to medium sized projects (those carried out at district or area level). Points covered in this paper are: site location and layout; survey of existing buildings; exploitation of existing building and site; design stage; personal involvement, morale and time scale; and interior decoration. A list of factors which must be recognized in upgrading existing health buildings is included, together with brief details, including cost, of actual examples of upgrading.

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

170. GECSER, O. Epületgépészeti berendezések központi vezérlése kórházakban. **[Centralized engineering installations in hospitals.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1978, June, vol. 16, no. 2, pp. 195-207.

The ever-growing number of hospital installations can be efficiently operated only with an automated central control unit. The number of technicians and the working-time spent in locating and repairing faults can be decreased and it is possible to save on cables and energy costs. The diagrams accompanying the article show a scheme linking

air-conditioning, hot water supply and medical gas supply systems. Two hospitals presently under construction—Kecskemet and South-Pest—will be equipped with these systems.

ELECTRICAL INSTALLATIONS AND EQUIPMENT

171. RIGGS, F. L. and KRUG, F. T. **In-house television news: focus on employees boosts morale.** *Hospitals*, Chicago, 1978, July 16, vol. 52, no. 14, pp. 91-93.

Tucson (Ariz.) Medical Center is using a monthly videotaped television news programme to effectively inform its departments and staff about one another, to provide them with special recognition, and to help nurture their esprit de corps. Each programme is produced in 16 hours and follows the format of television network news programmes. On-the-scene reports from throughout the hospital are co-ordinated by an anchorman in a newsroom. Each report runs for about two minutes and usually includes a segment in which an employee reporter interviews an employee news source. Each programme includes a 30- or 60-second 'Commercial'. The programme, a joint venture by the hospital's education and community affairs departments, is displayed in an enclosed dining area in the cafeteria. A self-repeating videotape player continuously presents the programme for two days so that staff from all shifts may see it. The programme is also circulated on a mobile television trolley to departments and units that ask for this service. Replies to a questionnaire indicate that the service fills a communications gap in an expanding major medical centre and helps to instil institutional pride and to raise staff morale.

ARTIFICIAL LIGHTING

172. ILLUMINATING ENGINEERING SOCIETY OF NORTH AMERICA. **Lighting for health care facilities.** *Lighting Design and Application*, New York, 1978, June, vol. 8, no. 6, pp. 19-40; July, vol. 8, no. 7, pp. 36-53.

This is a guide to the lighting of health care facilities and considers only areas that are unique to them. It covers: types of facilities; lighting objectives; lighting design considerations for individual areas; criteria for health care facility lighting; lighting design procedures; and lighting systems considerations. The bulk of the paper is taken up by a consideration of the requirements of individual areas. In addition to 32 photographs and diagrams, the paper includes tables showing recommended levels of illumination for various hospital areas, illumination on tasks, levels of illumination for safety, luminance ratios, and surface reflectances.

COMMUNICATION SYSTEMS

See also Abstract No. 257

173. WEAVER, D. K. and others. **Evaluation of a computer-directed pneumatic-tube system for pneumatic transport of blood specimens.** *American Journal of Clinical Pathology*, Philadelphia, 1978, Sept., vol. 70, no. 3, pp. 400-405.

The results of sending blood specimens through a computerized pneumatic system (Trans-Logic 200) and by manual delivery were compared for 15 chemical tests and

six haematological procedures. All specimens were collected from in-patients and out-patients into evacuated glass containers. The specimens traversed 829 feet (253 m.) involving 16 beds and eight transfer units at 25 feet (7.6 m.) per second. No breakage, spillage or leakage occured in any test. It was found that 14 of the 15 chemical tests and the six haematological tests, compared with the precision of controls, were unaffected by pneumatic tube transport. Only the activity of lactate dehydrogenase exceeded the precision of the test in pneumatically transported specimens. Ruptured erythrocytes in incompletely filled vacuum tubes were the likely source of the increased lactate hydrogenase activity. It is concluded that the pneumatic tube system provides a safe, efficient method of transporting the blood specimens tested.

TRANSPORT IN GENERAL

See Abstract No. 257

HEATING

174. GRIFFITHS, D. **Conservation through site generation: operational experience.** *Hospital Engineering*, London, 1978, Sept., vol. 32, no. 7, pp. 16-20, 22-25.

There is nothing new about using back pressure steam engines or turbines as generator prime movers and then using the exhaust steam for process work or heating. The essential principle is that the amount of electrical power generated is made entirely dependent on the variable demand for exhaust steam. During the normal running of the generator in parallel with the public electricity supply, the quantity of steam entering the engine is governed by back pressure control, which modulates to maintain the desired pressure in the exhaust steam supply. The first part of the paper outlines the theory and design of the system and its cost effects. The second part is a case study of the application of the concept in an acute district general hospital of approximately 450 beds. It is suggested that there can be benefits both in energy conservation and cost reduction from a correct application of this method of site generation. These benefits will be clearly dependent on efficient operation of the plant but are even more conditional upon decisions made during the design of the installation.

175. KENSETT, R. G. **Site generation for hospitals—the concept.** *Hospital Engineering*, London, 1978, Aug., vol. 32, no. 6, pp. 14-23.

The rationale for on-site generation for hospitals is first presented, with particular reference to the economic aspects, the need to protect at all times the essential electricity supplies, and the desirability of extending the use of air-conditioning in hospitals. A detailed explanation of site generation follows, together with a discussion of the thermodynamic aspects.

VENTILATION AND AIR-CONDITIONING

See Abstract No. 174

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See Abstract No. 201

EQUIPMENT, FITTINGS, FURNITURE

FLOORS AND FLOOR COVERINGS

176. BETHE, M. Teppichböden in öffentlichen Gebäuden—ja oder nein? **[Wall-to-wall carpets in public buildings—yes or no?]** *Öffentliche Gesundheitswesen*, Stuttgart, 1978, Oct., vol. 40, no. 10, pp. 679-688.

Carpeting is now widely advocated for certain areas in hospitals. The advantages and disadvantages are discussed in this paper. The conclusion is that carpeting is suitable in areas where infection or organic contamination is not expected (e.g., in psychiatric departments). However, carpeting is not suitable in areas where organically sick patients are cared for (i.e., patient's rooms, operating theatres, plaster rooms, out-patient departments, etc.).

EQUIPMENT GENERALLY

See Abstract No. 283

MEDICAL EQUIPMENT

See Abstract Nos. 196, 203

ELECTRONIC EQUIPMENT

See Abstract Nos. 262, 263

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract Nos. 184, 264

RECRUITMENT AND MANPOWER

See also Abstract Nos. 192, 304

177. MOBLEY, W. H., HORNER, S. O. and HOLLINGSWORTH, A. T. **An evaluation of precursors of hospital employee turnover.** *Journal of Applied Psychology*, Washington, 1978, Aug., vol. 63, no. 4, pp. 408-414.

To evaluate a heuristic model of staff turnover, survey data were collected from 20[illegible] hospital staff. The questionnaire included measures of general and facet job satisfaction,

thoughts about leaving, the intention to leave, the perceived probability of finding another job and biographical information. Turnover data were collected 47 weeks later. Zero-order correlations between job satisfaction and turnover, age-tenure and turnover, satisfaction and thinking of leaving, and intention to leave and turnover were consistent with previous research. When a simplified heuristic model of the employee withdrawal decision process was subject to regression analysis, significant coefficients were evident from job satisfaction to thinking of leaving and intention to search, but not to actual turnover. As hypothetized, intention to leave exhibited the only significant coefficient with actual attrition. The results support the primacy of intentions in the withdrawal process and serve to further demonstrate the need for models of the turnover process more complete than the traditional dissatisfaction-turnover model.

STAFF MANAGEMENT

See also Abstract No. 181

178. Soós, L. Munkaszervezés az integrált egészségügyi intézményekben, 2. **[Organization of work in hospital/polyclinic units, 2.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1978, June, vol. 16, no. 2, pp. 149-173.

The possibilities of co-ordinating the nursing needs of the population with the ward capacity are discussed. Staff activity models on a working-time basis are presented. The organization of servicing the wards is considered and the degrees of progressive patient care analyzed.

STAFF RELATIONS

See Abstract Nos. 171, 234

STAFF TRAINING

See also Abstract Nos. 182, 185-188, 193, 195, 196, 210

179. Banaszak, S. M. and Willner, R. F. **Clinical affiliations needed to augment educational experience.** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 169-170, 172-173.

In the education of health professionals, too little attention has been paid to the need for a solid clinical component. There is a need for a co-equal partnership between hospitals and educational institutions in the development and implementation of educational programmes. Clinical affiliation agreements must be carefully considered by hospitals and an internal decision-making model for such consideration is presented. The need for determining a cost/benefit equilibrium is stressed. Evaluations are an important part of the affiliation process. Planning should begin a full semester in advance and keep the academic calendar in mind.

180. Contis, J.-P. Plan de formation ou catalogue de formation? **[Plan of objectives or list of objectives?]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Aug./Sept., vol. 33, nos. 395/396, pp. 55-60.

The objectives and content of in-service training plans are discussed. In the Civil

Hospitals in Lyons the objectives are to prepare the most suitable candidates for promotion, to help all staff to adapt to new methods and techniques in the various fields of activity, and to develop employees' knowledge of hygiene and safety in order to maintain and improve the quality of patient care. The author examines the many constraints and difficulties encountered in the pursuit of these objectives.

STAFF WELFARE

See also Abstract No. 171

181. SILVER, D. F. **Counselling and peer review are key disciplinary procedures.** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 189-190, 192, 194, 196.

Dismissal is not always the best approach to the problem of an employee with a disciplinary problem. The Psychiatric Institute of Washington, D.C., has designed a system that recognizes the need for disciplinary action and ensures that supervisors become actively involved in counselling and in working with staff who pose disciplinary problems. The step-by-step approach involves an informal talk, verbal warning and a written counselling memorandum (example reproduced). If these do not bring about a change in the employee's behaviour, it may be necessary to place him on probation; this must be validated by a counselling memorandum and should not ordinarily exceed 90 days. A copy of the memorandum is sent to the personnel department. At the end of the probation period, the supervisor recommends that it be discontinued or extended or that the employee be dismissed. The department head may then recommend suspension or dismissal. The hospital also has a policy whereby all dismissals are investigated by a peer review committee; the guidelines for the committee are listed.

SPECIAL CLASSES OF STAFF

ADMINISTRATIVE AND CLERICAL STAFF

See also Abstract No. 202

182. PALMER, G. R. **Post-graduate education for health administration: the United States experience.** (Australian Studies in Health Administration No. 32) Washington, Association of University Programs in Health Administration (reprinted by the University of New South Wales, School of Health Administration), 1978, [ii], 36pp.

This report is based on visits to 14 training schools for health administration accredited by the Accrediting Commission on Education for Health Services Administration in the United States. The main objective of the report is to create a basis for developing strategies for overcoming similar problems in Australia or for avoiding their emergence in the future. Consequently the report focuses on the problems and difficulties of health administration education in the United States. A select bibliography of 28 items is included. Appendices list: the Health Administration Schools visited in the United States; estimates of future demand in the United States for administrators with graduate education in health administration; and health administration education in Australia.

MEDICAL STAFF

183. ROY-CHOWDHURY, S. **Medical assistants: mark II.** *British Medical Journal*, London, Aug. 19, vol. ii, pp. 584.

Although most hospital administrators and consultants are aware of the difficulties and anomalies faced by medical assistants, a few tend to undermine consultation with senior medical staff. However, the Department of Health and Social Security and the British Medical Association are now agreed that there should be more integration of medical assistants into the representative machinery of the hospital medical service. A Medical Assistants Subcommittee of the Central Committee for Hospital Medical Services has been active for two years and medical assistants must take advantage of the channels open to them to improve their position.

184. HOWITT, L. F. **Medical staffing in the National Health Service in Scotland.** *Health Bulletin*, Edinburgh, 1978, July, vol. 36, no. 4, pp. 196-203.

A series of nine tables prepared by the Scottish Home and Health Department show the staffing position in the National Health Service in Scotland in 1976, particularly that in the hospital service. The tables give: (i) the numbers of staff by specialty; (ii) the age distribution of consultants and principals in general practice; (iii) the age of first appointment as consultants and principals; (iv) the age on appointment as senior registrars; (v) the length of time as registrar; (vi) the length of time as senior house officer; (vii) the length of service in senior registrar grades on appointment as consultant in certain specialties; and (viii) medical staffing broken down by grade and specialty to show the number of United Kingdom graduates and to give some indication of the competition for promotion. Table ix shows the number of dental staff by age and specialty.

185. HUBBARD, J. P. **Measuring medical education: the tasks and the experience of the National Board of Medical Examiners.** 2nd edition. Philadelphia, Lea and Febiger & London, Kimpton, 1978, xi, 187pp. £9.00

This second edition was deemed necessary in view of the changes in policies and procedures of the National Board of Medical Examiners that have taken place since the first edition appeared in 1971. After outlining the evolution of measurement and evaluation in the United States, the book describes the mechanics of testing and discusses their validity. Other topics covered are: qualifying examinations derived from standardized test material; evaluation as a guide to learning in continuing education; research and development; and the National Board and the public interest. Appendices give the names of the senior staff of the National Board of Medical Examiners (January 1978), and 60 pages of examples of test questions with answers.

186. MOSS, T. J., DELAND, E. C. and MALONEY, J. V. **Selection of medical students for graduate training: pass/fail versus grades.** *New England Journal of Medicine*, Boston, Mass., 1978, July 6, vol. 299, no. 1, pp. 25-27.

The performance of two cohorts of surgical residents: one from 'pass/fail' and the other from 'graded' medical schools was analyzed. A performance index indicated that the group from graded schools performed significantly better ($P<0.001$). No

resident from a pass/fail institution ranked above 87 per cent and this group accounted for 82 per cent of those ranking under 15 per cent. It is recommended that a residency scheme seeking for excellence among its trainees would do well to select those students who apply from medical schools providing a specific ranking in the class as part of the total evaluation of the student.

187. STIMMEL, B. and SMITH, H. **Career choice and performance on state licensing examinations of 'Fifth Pathway' students.** *New England Journal of Medicine*, Boston, Mass., 1978, Aug. 3, vol. 299, no. 5, pp. 227-230.

Between 1975 and 1977, 340 American citizens trained in foreign medical schools (mostly Mexican) completed a year of supervised clinical training (Fifth Pathway) in New York State before beginning residency training. Analysis of 335 such students revealed a greater tendency to remain in the State for residency training as compared to graduates of New York State medical schools. Students chose a primary-care specialty less often than American graduates. However, their pass rate on state licensing examinations was lower than American-trained students. Fifth Pathway schemes can provide a source of house officers for hospitals currently staffed by foreign physicians. The schemes offer foreign-trained United States physicians an opportunity to improve their clinical skills before starting residencies, but evidently do not fully overcome their educational deficits.

188. BOYD, K. and others. **Teaching medical ethics: University of Edinburgh.** *Journal of Medical Ethics*, London, 1978, Sept., vol. 4, no. 3, pp. 141-145.

Part of the remit of Edinburgh Medical Group Research Project in Medical Ethics and Education was to explore the feasibility of integrated and multidisciplinary teaching of medical ethics both inside and outside of the medical school. These four papers by two full-time research fellows and two professional advisers, one nursing and one medical, give a picture of the wide scope of experimental teaching taking place in Edinburgh and present some preliminary results from these experiments. The papers are on: (i) experimental curriculum-related teaching of medical ethics; (ii) how nursing students learn about medical ethics; (iii) teaching and learning of medical ethics in Edinburgh—traditional aspects; and (iv) extra-curricular study of medical ethics.

189. BROOK, P. **Consultant psychiatrists: who are they and where are they going?** *Medical Education*, Oxford, 1978, Sept., vol. 12, no. 5, pp. 382-383.

This paper reports the fourth of a series of enquiries by postal questionnaires sent at three-yearly intervals to all newly-appointed consultants in general psychiatry in the United Kingdom enquiring about training and background. It covers those appointed between 1 October 1963 and 1 September 1975. The results show that there has been a sharp increase in the number of women and overseas graduates promoted to consultant. This trend will continue because of the rising numbers in these two groups who are now in senior registrar posts. What is of concern is that the majority of both groups have received most of their training at non-teaching psychiatric hospitals and units. It would be highly undesirable to have a two-tier system of training, especially one based on sex and country of qualification. The increase in the numbers of medical assistants strongly suggests that there are not enough senior registrars in post. As in the last survey, two important findings are the substantial proportion of consultants who might

have emigrated, and the small number who would have switched to a specialty if their plans had failed to materialize. A new and more disturbing finding is that established consultants are emigrating.

NURSING STAFF

See also Abstract No. 244

190. GROSVENOR, P. **Nursing in theory 1972-77—1.** *Nursing Times*, London, 1978, July 27, vol. 74, no. 30, occasional papers, pp. 81-84.

This article is a review of the literature on nursing in theory, published between 1972 and 1977. The author considers that both the quality and the quantity of such books increased during these years, owing to the growth of further training and research in nursing. The books reviewed are divided into five categories; (i) history; (ii) professional development; (iii) education; (iv) management; and (v) research. Those books that consider changes in the profession reflect the increasing awareness of the role played by sociology in nursing, the role of the nurse in the community and the emergence of specialties within the profession. The section on education includes books on the nurse both as student and teacher.

191. LEVINE, J. I. and others. **The nurse practitioner: role, physician utilization, patient acceptance.** *Nursing Research*, New York, 1978, July/Aug., vol. 27, no. 4, pp. 245-254.

A comprehensive study of nurse practitioners was undertaken to evaluate the nurse practitioner training programmes of the University of Virginia and to determine the effectiveness and responsibilities of nurse practitioners in various practical settings. Data on nurse practitioners in a number of locations in Virginia and in the Philadelphia metropolitan area were collected and analyzed to determine the way in which nurse practitioners' time was allocated among various duties and to evaluate nurse practitioner performance by physicians and patients. Nurse practitioners performed a wide variety of clinical and non-clinical tasks. Most physicians were satisfied with the practitioner's performance although there was some inconsistency between physicians and nurse practitioners regarding actual duties performed. A high percentage of physicians stated they would hire a nurse practitioner to replace one who left their employ. Physicians' reasons for hiring a nurse practitioner, as well as their previous contact with such staff, were examined. Regarding patient attitudes towards nurse practitioners, data indicated that patients were satisfied with nurse practitioners and felt comfortable being treated by them.

192. KEAVENY, T. J. and HAYDEN, R. L. **Manpower planning for nurse personnel.** *American Journal of Public Health*, Washington, D.C., 1978, July, vol. 68, no. 7, pp. 656-662.

A technique is described which can be applied to manpower planning for nurses at a state or regional level. The implications of alternative planning policy decision strategies intended to balance manpower supply and requirements are discussed. The effect of the following policy alternatives are estimated: scale of operations of training schools; interstate migration patterns; size of labour force; and the job descriptions of the licensed practical nurse and the registered nurse.

193. MOORE, F. I. and SINGLETON, E. K. **A 'temporary systems' approach to nursing education in a health care organization.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, July, vol. 8, no. 7, pp. 7-14.

A 'temporary systems' approach to providing nursing education consists of the organization of the appropriate resources into temporary task forces to provide specific educational services to those employees in nursing service. The focus of this approach might be expanded to encompass the provision of educational services to selected individuals, groups or organizations external to the institution. The first part of this paper discusses the purposes, goals and objectives of nursing education. It then goes on to describe a grid approach to organizing staff for activities of the education department. The activities included are: staff development and continuing education for nurses; staff development for selected categories of allied health staff; orientation and information services for referral and referring agencies; co-ordination of requests and monitoring of events related to clinical or practice experiences; and response to other nursing-related special requests for orientation or special learning experiences. The roles of the task forces are defined as: activity manager; participant liaison; faculty liaison; materials developer; evaluation specialist; medical science specialist; behavioural science specialist; management science specialist; nursing science specialist; logistics co-ordination; and administrative assistant. Advice is given on filling these roles.

194. PERRY, S. E. **Managing to avoid malpractice. Part 1.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, Aug., vol. 8, no. 8, pp. 43-47.

The nursing manager can lessen the risk of malpractice suits by ensuring that the methods used by her staff are up-to-date and that supplies and equipment are adequate and safe. A supervising nurse is responsible for the actions of those working under her and both may be sued by the patient for the same act of negligence. It is the duty of the nursing manager to inform the physician if any patient is not clear about what is involved in any recommended course of treatment. There should be written job descriptions for every post in the nursing department and a mechanism for dealing with employee grievances is needed. Student nurses must not perform tasks for which they are not prepared and in-service continuing education should be provided for those already qualified. The nursing manager should work closely with the administration to ensure that staff-patient ratios are high enough to deliver quality patient care.

195. BOREHAM, N. C. **Test-skill interaction errors in the assessment of nurses' clinical proficiency.** *Journal of Occupational Psychology*, London, 1978, vol. 51, no. 3, pp. 249-258.

The accuracy of tests of clinical proficiency in nursing depends not only on the nature of the test instrument used, but also on the type of skill being assessed. A task analysis of the nursing care for a patient receiving peritoneal dialysis reveals that it involves a diverse range of skills. Four types of practical examination commonly used in nursing (self-report, simulations, the ward-based examination, and continuous assessment) are each relatively sensitive to some of these skills, and relatively insensitive to others. Different types of test are sensitive to different types of skill. Hence, no one test technique can be expected to sample adequately all aspects of performance in the nursing task investigated, and so the whole range of techniques should be used, successful

performance in individual tests being interpreted as necessary but not sufficient evidence of mastery.

OTHER PROFESSIONAL AND TECHNICAL STAFF

196. WATTEAU, J. P. **Biomedical engineering education in France.** *Journal of Medical Engineering & Technology*, London, 1978, July, vol. 2, no. 4, pp. 178-181.

The pioneers in biomedical engineering tuition in France were people who were both doctors and engineers, who organized short, very practical lectures for doctors, engineers or technicians. After passing his matriculation or baccalaureate at about 18 years of age, the French student can continue his studies at three successive levels. The programmes in biomedical engineering at these levels are: (i) first advanced level courses for high-level technicians with a baccalaureate plus two years specialization; (ii) second advanced level courses lasting three years and leading to a degree in engineering, with biomedical engineering as a possible specialization in the final year; (iii) third advanced level, for graduates from courses at the previous level who may or may not have received tuition in biomedical engineering; and (iv) postgraduate courses for doctors or engineers. Career openings and related problems are also discussed.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 166, 170, 174, 194, 208, 209, 216, 223, 227, 238, 284

197. JACOBS, M. O. **Administrators, boards, physicians must help change health system.** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 78-80.

Changes in the health care system are inevitable and hospital administrators, boards and medical staff must learn not only to accept change but also to participate in effecting it. They must promote co-operation among hospitals, become more informed about the system's problems and pressures for change, and participate in activities of health systems agencies and other health-related groups that plan and influence change. Ways in which each of the three groups can do this are mentioned briefly.

198. BRUNET-JAILLY, J. and others. Étude pilote d'un centre hospitalier. **[Pilot study of a hospital centre.]** *Santé, Securité Sociale Statistiques et Commentaires*, Paris, 1978, July/Aug., no. 4, pp. 5-20.

This is a summary of an attempt made by a multidisciplinary team to describe the way in which a 365-bed hospital with 600 employees and running costs of 46,000,000 francs operates and the improvements they propose. The summary is divided into four sections: (i) features of the clientele, reasons for admission, and behaviour of the care team; (ii) a sociological interpretation of the operation and power structure of the establishment; (iii) programme for changes; and (iv) reflections on medium-term trends. It was found that for the 10 per cent of patients who appeared to have been admitted for social rather than medical reasons, laboratory and X-ray tests were carried out simply because the patients were there; the allocation of nursing staff was defective in terms of need, and internal norms were inflexible. The main source of dysfunction was compartmentalization into departments and specific units, not specific patients. The team suggested that the patient's passage through the hospital should be organized

as a function of his illness and not of the system, that medical and paramedical staff should be organized in teams, not in departments, and that the decision-making structures and methods of financing should be re-organized.

199. LIVELY, C. A. **P.L.93-641: a recipe for action.** *Hospitals*, Chicago, 1978, July 16, vol. 52, no. 14, pp. 65-68, 124.

The United States National Planning and Resources Development Act of 1974 (P.L.93-641) was drafted after years of intensive study of health planning and development activities. This paper examines: who needs the act; federal, state and local responsibilities under the act; development of health systems plans by the local health systems agencies appointed under the act; and potential problems relating to national health planning guidelines, appropriateness review, certificate of need, representation, and codes and standards. The health planning law should give local community providers and consumers a better opportunity to make health planning work, but its success will depend on the willingness of the community to effect change through local decision making.

200. FRIEDMAN, E. **The first fully designated HSAs begin a long, exacting job.** *Hospitals*, Chicago, 1978, July 16, vol. 52, no. 14, pp. 69-74.

Four of the first fully-designated health systems agencies (HSAs) are located in Buffalo and Rochester, NY, and in Cincinnati and Indianapolis. This paper presents profiles of these HSAs, with particular reference to their priorities, their major activities and their relationships with hospitals. They show that the HSAs are tackling a variety of health care delivery problems with a wide range of possible solutions. Relationships with providers, the nature of the areas involved, political considerations, and history are all playing a part in shaping the identities of these new agencies.

201. ELLIS, B. **New sharing arrangements meet hospitals' technical support needs.** *Hospitals*, Chicago, 1978, Aug. 16, vol. 52, no. 16, pp. 108-110, 112-113.

Within the past decade, a variety of multi-hospital arrangements have been developed that make clinical engineering services available to hospitals on a shared basis. This paper summarizes available data on the diverse approaches and organizational structures which are evolving in these programmes and compares their advantages and disadvantages. The benefits of shared services include: true economy of scale; avoidance of duplication of services; staffing economies; the ability to attract staff with more expertise; and the sharing of experiences and co-operation in problem solving.

202. DISEKER, R. A. **The autonomy loss index: measuring autonomy lost by hospital administrators through participation in joint programs with other organizations.** *Social Science and Medicine*, Oxford, 1978, July, vol. 12, no. 4A, pp. 293-296.

Joint hospital schemes and shared services are increasingly advocated as the best methods of rationalizing health care. However, one of the results of these joint schemes is the loss of administrative autonomy in return for the resources of other institutions. Hospital administrators considered autonomy to be of importance in five areas of the joint schemes. Each of these areas was represented by statements concerning actual conditions of participation. The conditions were evaluated. The total of the individual

weights attached to all of the conditions evaluated by the administrators for a specific joint scheme provided an index to the amount of autonomy lost.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 175, 218, 219, 235, 258, 259, 263, 295

203. WARNER, K. E. **Effects of hospital cost containment on the development and use of medical technology.** *Milbank Memorial Fund Quarterly/Health and Society*, New York, 1978, vol. 56, no. 2, pp. 187-211.

The factors affecting the development and use of medical technology are discussed. The most direct impacts of a limitation on total in-patient revenue relate to the acquisition and use of technology within hospitals. These first-order effects include: decreased use of technology already in place; substitution of existing lower-cost alternatives to tests or procedures of choice; reduction in the flow of new cost-increasing technology into the practice of medicine, particularly in hospitals; increased interest in and consumption of new cost-saving technology; decreased diffusion of new technology; and increased hospital and area-wide co-operation and co-ordination. Derivative, or second-order, effects on other health care institutions reflect incentives to shift resource-intensive care to these other settings: the 'dumping' of expensive cases on other institutions; shift in the use of cost-increasing technology from hospitals to private physicians' offices; and a shift in the use of technology from an in-patient to an out-patient basis. If a revenue limit diminishes the market for cost-increasing technology, one would expect to see a reduction in private sector research and development (R & D) activity directed toward cost-increasing technology, greater price competition and lowered hospital costs, most R & D on production of cost-saving technologies, and little effect on basic bioscience research. A ceiling on capital expenditure would result in first-order effects of: decrease in the acquisition by hospitals of expensive capital-intensive technology; and search for diagnostic and therapeutic alternatives with lower component prices. Second-order effects would include: decrease in technology-oriented applied R & D; decrease in the development of all high capital cost technology; and little effect on basic bioscience research.

204. KINGSDALE, J. M. **Marrying regulatory and competitive approaches to health care cost containment.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1978, vol. 3, no. 1, pp. 20-42.

There has been considerable debate in the United States on the relative merits of regulatory and competitive approaches to health care cost containment. The thesis of this paper is that the most important choice in health policy-making is not public versus private control but the most effective strategy, among numerous options, for integrating regulatory and competitive mechanisms designed to hold medical care providers accountable for the cost as well as the quality of their services. Accountability is the central issue. It is suggested that public regulation which accommodates the special characteristics of health maintenance organizations (HMOs) allows for effective competition. Although there are formidable difficulties in formulating the appropriate regulatory strategies, there are some encouraging signs that future policy may minimize

conflict between regulations and competition. These include, the renewed commitment of the Administration and Congress to the development of HMOs and the active interest of the Federal Trade Commission in health care.

205. RAPHAELSON, A. H., and HALL, C. P. **Politics and economics of hospital cost containment.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1978, vol. 3, no. 1, pp. 87-111.

Voluntary and regulatory efforts toward hospital cost-containment have accelerated with rapid increases in those costs and under the pressures of national health insurance. Possible causes of hospital inflation are examined in the context of market analysis and with reference to the nature of hospitals as institutions facing special combinations of economic and political conditions and pressures. These causes include: hospital market behaviour; demand pressures; flexibility; nature of output; input markets and prices; and resource management and use. Some details of voluntary experiments and state regulatory efforts are examined, with particular reference to Maryland, in order to assess the elements of experience to date and their relationships to causes of hospital inflation. Federal proposals for a regulatory 'cap' on costs are also discussed with a view of how such proposals are related to probable causes of hospital inflation and of the relevance of other experience.

206. BROOK, R. H., WILLIAMS, K. N. and ROLPH, J. E. **Use, costs, and quality of medical services: impact of the New Mexico Peer Review System.** *Annals of Internal Medicine*, Philadelphia, 1978, Aug., vol. 89, no. 2, pp. 256-263.

This evaluation of four years' data on the review of medical services for the Medicaid population shows that: (i) utilization review had no demonstrable impact on hospital use—hospital days per 100 eligible persons rose by 5.0 per cent, and by 43.4 per cent for persons enrolled for all four years in Aid to Families with Dependent Children (AFDC) and Aid to the Permanently and Totally Disabled respectively; (ii) peer review produced no net cost savings—over four years the amount paid for all services per AFDC-eligible person rose 85 per cent; and (iii) peer review improved the quality of ambulatory care through large reductions (75 per cent) in medically unnecessary injections. If the findings are repeated elsewhere, they suggest that the goal of the professional standards review organizations (PSRO) programme to control costs by curtailing use may be difficult to achieve, the quality of care goal may be pursued successfully, and the PSRO mission should be focused more on the latter.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 273, 291

207. REES, L. T. **Comparing hospital resources.** *British Medical Journal*, London, Aug. 19, vol. ii, pp. 582-583.

This paper describes a method of visually presenting data concerned with patient turnover, bed numbers and medical staffing in hospitals in the seven health areas of Wales. Patient turnover, bed availability and consultant staffing levels in each area are equated to local population and expressed as percentages of Welsh averages. The information is then incorporated into diagrams concerned with either a single specialty

throughout the region or with several specialties in one area. These profiles make it easy to recognize any anomalies in the distribution of resources which may need further study by the relevant authorities. A sample profile is illustrated for: (i) otorhinolaryngology; (ii) geriatrics; and (iii) one area presenting similar data for several specialties.

208. RODE, E. A. **Hospital bed needs defy cut-and-dried planning.** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 81-83.

Four types of primary planning models are used in the United States: regression methods, formula models, stochastic methods and simulation models. The types and uses of beds vary so widely that these strict models cannot be used to determine bed needs adequately or to indicate adequately a community's total health care needs. Planners must therefore recognize the limitations of all mathematical models that they try to apply to people and institutions, and they must recognize the profound implications for patients, their families and, very often, their communities.

209. UNITED STATES. HEALTH RESOURCES ADMINISTRATION. **National guidelines for health planning.** March 28 1978. (DHEW Publication No. (HRA) 78-643) Washington, U.S. Government Printing Office, 1978, xiii, 75pp.

This monograph reprints the National Health Guidelines issued on 28 March 1978 by the Department of Health, Education and Welfare. This is accompanied by a reprinting from the Federal Register of the Preambles to the final rule and to the two notices of proposed rulemaking which preceeded the final rule. These guidelines consist of 11 resource standards covering hospital bed-population and occupancy rates; maternal, infant and paediatric health services; open heart surgery and cardiac catheterization; radiation therapy; computed tomographic scanning; and end-stage renal disease. A second set of guidelines will be published consisting of goals relating to health status, health promotion and prevention, and access to health care. A selected bibliography is included.

ELECTRONIC DATA PROCESSING

See Abstract Nos. 210, 212, 214, 224, 225, 250, 260

INFORMATION SYSTEMS

210. **[Medline].** *Medical Informatics*, London, 1978, Sept., vol. 3, no. 3, pp. 165-254.

MEDLINE, the on-line development of the Medical Literature Analysis and Retrieval System (MEDLARS) became available in 1971. This issue is devoted to seven papers by members of the staff of the National Library of Medicine. They deal with: training and continuing education for on-line searching; users, usage and economics; data communications; hardware and software; the on-line user network—organization and working procedures; searching and retrieval. The papers present full accounts of the technical and administrative problems encountered and the solutions devised.

211. AUSTIN, C. J. and GREENE, B. R. **Hospital information systems: a current perspective.** *Inquiry*, Chicago, 1978, June, vol 15, no. 2, pp. 95-112.

This paper examines the current state-of-the-art of information processing in hospitals for both clinical and administrative purposes. The objectives are: (i) to evaluate the extent to which information systems support management processes; (ii) to determine the major problems and conceptual limitations in present approaches to system development; and (iii) to suggest directions for future research aimed at current problems and limitations. The review suggests that there has been some success in the development of hospital information systems. Moderate to good progress has been achieved in the design and use of computer and automated information systems for direct patient care, and some clinical systems are now being extended beyond the research and development stage to operational use. Fully integrated information systems for the first time appear to be cost-effective for hospitals with 250 beds or more. However, these systems are still oriented primarily towards day-to-day operations rather than management and control. Reasons for lack of progress in development of systems for the latter purpose fall into five categories: technological limitations; economic factors; external factors; conceptual limitations; and managerial shortfall. A list of 166 references to the literature is included.

212. SHAFFERT, T. K., editor. **Hospital information systems.** *Topics in Health Care Financing*, Germantown, Md., 1978, vol. 4, no. 4, pp. 1-107.

This issue is devoted to the role of management information systems in the hospital and health care industry. After an introductory overview of the subject there are papers on: current status and trends of hospital information systems; patient management systems; clinical/ancillary systems; financial systems; organizing for systems development; evaluating and selecting a computer system; and a management perspective.

MEDICAL RECORDS

See also Abstract Nos. 211, 212

213. HARRIS, R. J. **Faciliating change to the Problem-Oriented Medical Record system.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, Aug., vol. 8, no. 8, pp. 35-38.

The Continuing Education Program at the School of Nursing, University of North Carolina, set up a project to help various units implement a Problem-Oriented Medical Record System (POMR). Control of patient management and records by doctors and administrators was the chief obstacle encountered by nurses. Other obstacles were: (i) the attitude of some nurses; (ii) the lack of clarity regarding the scope of nursing practice; and (iii) the inconsistency of recommendations from outside agencies regarding POMR. Examples are given of ways in which nurses can change attitudes, both within their own place of work and on a state or federal level through their professional organizations. The most appropriate way to implement the POMR system depends upon the urgency of the need for change and the ultimate goals of the institution concerned.

214. TUDGE, C. **What a waste of data.** *World Medicine*, London, 1978, Sept. 6, vol. 13, no. 24, pp. 21-23, 25-26.

Medicine cannot progress except haphazardly, and with great waste of time and resource and unnecessary heroism, unless data on patients and what is done to them and how they subsequently fare, are kept and assessed in orderly fashion. Great Britain, by virtue of the National Health Service, has the necessary data with patients' medical records. This paper suggests, however, that this data is being wasted for the emotional reasons that we are congenitally afraid of keeping tabs on people and have a fear of computers. Some studies of record linkage are discussed and the arguments against linkage are refuted.

HOSPITAL STATISTICS

See Abstract No. 165

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 194, 199, 204

215. WILFORD, N. B. **Program expedites reporting, resolving medical incidents.** *Hospitals*, Chicago, 1978, July 16, vol. 52, no. 14, pp. 83-84, 87-90.

The key to success in initiating and implementing an effective risk management programme is simplicity. The recommendations in this paper are based on experience at Halifax Hospital Medical Center, Daytona Beach, Fla. They cover: appointment of a risk manager; orientation of all employees; establishment of procedures; monitoring system; briefing the medical staff; the role of the medical incident committee; and financing the programme.

216. ROGATZ, P. **Creative responses needed in controlled environment.** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 73-77.

Faced with an increasingly regulatory environment, hospitals must find innovative ways by which to survive and, to respond constructively to externally applied constraints. Possible responses include: decertification of beds; incentives and disincentives to persuade physicians to practice in locations of need; rational distribution of funds amongst all hospitals in a community; and a move towards ambulatory services, including screening and preventive services. The key to success will be the measure of co-operation between health care providers, insurers and government.

217. SLUYTER, C. K. van and HAYS, P. G. **Interdisciplinary task force designs risk management program.** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 87-88, 90.

When the Methodist Medical Center of Illinois, Peoria, Ill., was confronted with non-renewal of its liability insurance and with exorbitant premium quotations from

alternative carriers for less than half of its previous coverage, it solved the problem by implementing self-insurance. At the same time, it realized that it needed a more comprehensive risk management programme to protect its operating assets. To develop this programme, an interdisciplinary task force was established. The task force reached consensus on five basic elements of a risk management programme: policies and procedures; qualified staff; the provider/patient relationship; education of staff and students; and claims review. Sub-committees involving as many members of the staff as possible were established to deal with these elements. The activities of the sub-committees are outlined. The task force and sub-committees have produced two major policies: an aggressive, institutionally-based claims review system; and the decision that risk management is a hospital-wide responsibility. Although the new programme coincided with new and expanded services, during 1977 patient-related incidents dropped 7.5 per cent per patient day and 7.2 per cent per admission. No malpractice claims were brought against the hospital in 1977 or during the first six months of 1978.

FINANCE AND ACCOUNTING

COSTS

See also Abstract Nos. 205, 287

218. ROFFE, B. D. and LAMY, P. P. **Hospital costs: can the inflatory spiral be stopped?** *American Pharmacy*, Washington, 1978, Sept., vol. NS18, no. 10, pp. 16-22.

The causes of inflation in hospital costs in the United States are reviewed. They include: wage increases; soaring malpractice premiums; the effect of government regulations and programmes; increased number of beds; over-use and duplication of services; and increased level of care. Attempts to control rising costs are also outlined. It is concluded that no single course of action can control the inflationary spiral.

219. SCHROEDER, S. A. **Group practice recommendations of the Committee on the Costs of Medical Care.** *Milbank Memorial Fund Quarterly/Health and Society*, New York, 1978, vol. 56, no. 2, pp. 169-186.

The first and most controversial recommendation of the Committee on the Costs of Medical Care, published in 1932, was that, in the future, medical services should be furnished largely by organized medical groups, hospital-based and regionally organized. In contrast to the recommendations of the Committee, the prevailing form of group practice today is distinguished by a limited range of services provided by medical specialists under fee-for-service financing. This paper re-examines the committee's recommendations in terms of their appropriateness to the medical care and medical politics of today, and considers why they have not been adopted. Some of the changes in medical care since 1932 are outlined and organized group practices are examined in more detail. The implications for a better understanding of future efforts at medical reform are also discussed.

FINANCE

See also Abstract No. 217

220. DAVIDSON, S. M. **Variations in state Medicaid programs.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1978, vol. 3, no. 1, pp. 54-70.

Many federal laws permit the states considerable latitude in determining the important characteristics of programmes created under them. Yet, this aspect is frequently overlooked in analyses of differences in state-level programmes. This paper presents a measure to aid in the analysis of one such programme, Medicaid, and to illustrate some of the ways in which it can be useful. The Medicaid Programme Index (MPI) differentiates among the Medicaid programmes according to four important characteristics: inclusion of the medically indigent; the optional services covered; limitations on the provision of basic services; and arrangements for paying providers. It is shown that the states vary considerably on these factors. Uses of the MPI include: (i) identifying variations between state programmes; (ii) accounting for those differences by comparing them to promising explanatory variables; (iii) identifying trends in programme characteristics over time; and (iv) developing hypotheses to account for these trends.

221. WOODWARD, A. **The U.S. health insurance industry: an alternative view.** *International Journal of Health Services*, New York, 1978, vol. 8, no. 3, pp. 491-507.

The health insurance industry in the United States can be characterized as a 'concentrated' industry, or one in which a small number of firms control most of the business. It has evolved into its current structure as a result of certain historical conditions, particularly those following the great depression. The structure of the industry has had an effect on the manner in which it functions and on the cost increases in health care. Specifically, the pricing mechanism is that of a price leader setting a limit price; health insurance premiums are higher than would be expected under a competitive structure. Regulation has been ineffective because it has been dominated historically by health care providers and insurers. The costs of health care in general, and hospital care in particular, have increased beyond what would be expected as a result of 'cost-pass-through'.

HOSPITAL ACCOUNTING

222. MAGEE, C. C. and OSMOLSKI, R. J. **A comprehensive system of management information for financial planning, decision making and control in the hospital service.** Coventry, University of Warwick, Centre for Industrial, Economic and Business Research, 1978, 37pp. £0.75

To be effective, any system of managerial financial planning and control in the English hospital service must be integrated, operated on a national basis and is therefore best organized centrally by the Department of Health and Social Security (DHSS). An adequate system of financial control is needed to ensure the best use of resources. This should be done by linking specialty costing and hospital activity costing to a procedure for the allocation of resources based on need, probably via some method to assess the amount of care provided. Comparisons of costs and care provided must be

made between the Regions and the Area, and high cost activities investigated. Such a system would have to be developed as part of a long-term plan. However, as a preliminary step a system of hospital accounting could be introduced to analyze expenditures of specialty groups, which would be sufficiently accurate to allow a start to be made on the development of a comprehensive system of financial planning and control. The feasibility of establishing specialty costing without too great expense is discussed in the light of research carried out at Bridgend General Hospital.

SUPPLIES AND STORES

SUPPLIES

223. SALMON, B. L. **Centralization—good or bad?** *Hospital and Health Services Review*, London, 1978, Sept., vol. 74, no. 9, pp. 313-318.

In his address to the Institute of Health Service Administrators' annual conference, the Chairman of the National Health Service Supply Board Working Group considers centralization as it affects the Department of Health and Social Security and the regional and area health authorities. He believes that the present structure of the health service can determine how much the various support services and functions should be centralized. These services fall into four groups: (i) staff and training, works services and planning; (ii) laundry and transport; (iii) domestic and catering services; and (iv) supplies. Group one requires representation at all levels of the NHS structure, but the second group should be controlled by the area. Group three can best be controlled at district level. The provision of supplies involves the commercial expertise of winning contracts, storage, stock control and distribution and can best be achieved by central, regional and area contracting carried out by professional staff. The author outlines his view of the duties of regional and area authorities. The discussion following the address is given.

ECONOMIC USE OF SUPPLIES, DISPOSABLES

See Abstract Nos. 233, 237

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

See also Abstract Nos. 230, 231

224. DANEELS, F., VERHAEGEN, W. and DEWULF, J. Computergestuurde voedselhuishouding: in academische ziekenhuizen te Leuven beheert de computer voorraad en budget. **[The computerized catering budgetary system at the Leuven University Hospital, Belgium.]** *Voeding- en Huishoudgids*, Amsterdam, 1978, May 1, vol. 45, no. 545, pp. 222-224.

This system provides: (i) a wide choice of menu at short notice (from 200 to 300

components at half a day's notice if required); (ii) speedy issue of distribution lists which makes for high efficiency in catering and transport, thus requiring less staff; (iii) better control of non-perishable stock and perishable purchases; and (iv) quick, daily information on costs. The hospital provides three meals a day for 1,000 patients with 550 normal and 450 special diets, processed through 15 production chains. Two types of menu cards are issued: a standard card for plain, non-seasonal foods and a weekly card including non-seasonal products. Patients' choices of menus are collected in the afternoon for the following day and entered on specially printed marking sheets for the computer. This results in issues for immediate use, such as individual meal tickets showing menu components and nutrients, and in the storage of data for future statistics. From control tickets costs per meal can be calculated. The system can also provide lists of variable data of food issues per nursing unit, production totals, stock lists of cold drinks, the kitchen distribution lists, etc. The paper includes examples of a weekly menu list and of a marking sheet, a table illustrating a brief description of the computer system (two IBM 370/180 computer systems with memories of 512 and 1,024 kilobytes, storing capacity of 1,810 megabytes, printing speed of 1,200 lines per minute, 26 terminals connected to three channels for data communication), and two photographs.

225. UNKLESBAY, N. and UNKLESBAY, K. **An automated system for planning menus for the elderly in Title VII Nutrition programs.** *Food Technology*, Chicago, 1978, Aug., vol. 32, no. 8, pp. 80-83.

Under the United States Nutrition Program for the Elderly, participating facilities are required to provide a low-cost meal which provides at least one-third of the National Research Council's recommended dietary allowances for the elderly. This paper describes the computerized menu planning system developed for the 236 facilities in Missouri. The data base is in two parts: (i) food component-name, purchase quantity, weight, cost, nutrient content, availability as a United States Department of Agriculture commodity, and seasonal availability of 608 food items; and (ii) menu item-name, serving size, description codes, yield, last date served, food preference, nutrient content, food cost, and seasonal availability. A concise flow chart of the menu planning process was developed and converted into programs for performing the menu selection process. Acceptable menus are entered into the report data file which is used to supply data to the report generating programs and to accumulate information for the entire year, so that planned menus can be periodically reviewed. Five management reports are generated by the system: participants' menu report; nutrition staff menu report; recipe ingredient report; report of average daily food costs; and report of monthly, quarterly and annual food costs.

226. FEE, T. **Shared services and ready foods system: a case history.** *Administration Hospitalière et Sociale*, Montreal, 1978, July/Aug., vol. 24, no. 4, pp. 14-18.

This is an informative account of the introduction of a ready-food system at Henderson General Hospital, Hamilton, Ontario. Menus, ingredients, equipment, production processes, packaging processes, and sanitary control process are described. It is intended that all the food for Hamilton General Hospital, four miles away, will be produced at Henderson General Hospital, and the frozen products transferred from

one hospital to the other in insulated fibre-glass containers with a capacity of 15-20 cubic feet. The author stresses the need to educate staff in advance of a change-over to a ready-food system, and also the need for strict control of sanitation techniques. Henderson General Hospital has an in-house microbiologist who carries out random sampling of food and equipment weekly. Details of cost analysis, capital investment, and budget estimates are given in three tables.

227. DUROCHER, J. Essai de modélisation des services alimentaires. **[A theoretical model of the organization of hospital food services.]** *Administration Hospitalière et Sociale*, Montreal, 1978, July/Aug., vol. 24, no. 4, pp. 8-9.

The author uses two diagrams to illustrate his food services model. In the first, the food department is a 'black box' around which four categories of environmental variable gravitate: human, material, financial, and technological resources. The second diagram shows that the basic information required to make the system operate comes from outside the system (food depends on availability, nutritional standards depend on the people to be fed, and staff are allocated as a function of the resources of the establishment and/or government). Activities within the system can be grouped into: (i) planning of menus and supplies; this influences every activity in the system; (ii) execution, provisioning, production, distribution, maintenance; and (iii) control of expenditure and quality.

228. DUROCHER, J. Production—distribution: perspective d'avenir. **[Production —distribution: future developments.]** *Administration Hospitalière et Sociale*, Montreal, 1978, July/Aug., vol. 24, no. 4, pp. 24-26.

The disadvantages of using traditional hot-line food production for institutions and the advantages of cold-line technology, in either the cook-chill or cook-freeze version, are discussed. The advantages include: greater automation of equipment; centralized production for more than one establishment; the production of seven days' meals in a five-day week; and the elimination of peak periods in the kitchen. Private enterprise may have a role to play, by providing some or all of the meals for institutions. This is the system employed at the Queensway-Carleton Hospital in Ottawa.

229. RAYMOND, D. **Trends in cook-chill, cook-freeze and reconstitution equipment.** *Administration Hospitalière et Sociale*, Montreal, 1978, July/Aug., vol. 24, no. 4, pp. 27-30.

A comprehensive review of developments in cook-freeze and cook-chill food production and a summary of the performance objectives and equipment components for each system are followed by a discussion of future trends. These will be influenced by the need to conserve energy, to solve some aspects of the original problems still present in these systems, and the need for better integration of auxiliary components. Recent developments which are mentioned include the use of pressure-less steaming for reconstitution, a self-generating steam source for all steamers, modifications to convection ovens, standardization of racks for single rack loading, commissary-type production for more than one institution, and the use of open rather than closed systems for greater flexibility.

DIETETICS IN THE HOSPITAL

See also Abstract No. 225

230. POTVIN-ROUSSEAU, R. L'informatique au service de la diététique.[**Computer-aided dietetics.**] *Administration Hospitalière et Sociale*, Montreal, 1978, July/Aug., vol. 24, no. 4, pp. 32-35.

The author examines the contribution that data processing can make to the dietetics department and describes the various programs currently available for menu planning, nutritional analyses of menus, administration (inventory control, cost control, quantity forecasting), data banks on foods, and data banks for recipes. He suggests that a pilot study should be carried out in one Quebec hospital, using one of the systems which have been developed in the USA, such as FOODS (Food Operation Ongoing Data System), FOOD MANAGEMENT SYSTEM, or DIETETIC COM-PAK.

231. RIENDEAU, N. Service alimentaire ou diététique: la recette n'est pas simple. **[Food service or dietetic service: there is no simple recipe.]** *Administration Hospitalière et Sociale*, Montreal, 1978, July/Aug., vol. 24, no. 4, pp. 36-39.

The terms used in the various types of food preparation systems for institutions are explained; this is followed by advice on the need for caution and careful assessment before embarking on a change-over to new methods of production. What is appropriate to a profit-making hospital in the United States is not necessarily appropriate for a state hospital in Quebec.

232. LAROCHELLE, Y. Prévention et milieu curatif: deux mondes irréconciliables? **[Prevention and the curing environment: two irreconcilable worlds?]** *Administration Hospitalière et Sociale*, Montreal, 1978, July/Aug., vol. 24, no. 4, pp. 5-7.

This is an account of a 'prevention through nutrition' campaign run in a Quebec hospital and directed at both patients and staff. The campaign was more successful among staff than among patients; the eating habits of the latter were considered to be difficult to change, and the patients were apathetic as regards information meetings organized to explain the Canadian Food Guide to them. They regarded 'diet' food as insipid and disgusting.

LAUNDRIES AND LINEN SERVICE

HOSPITAL LINEN AND TEXTILES

233. MITCHELL, N. J. **Disposable clothing for the operating room.** *Middle East Health Supply & Service*, Sutton, 1978, Aug./Sept., vol. 2, no. 8, pp. 78-80.

Single-use disposable gowns made of non-woven fabric are comfortable to wear in the operating room and retain shed skin particles. The amount of bacteria shed was reduced by 70 per cent when unscrubbed staff wore gowns, shirts and trousers made of non-woven fabric. Elasticating the shirt sleeves reduced bacteria dispersal by a further third. When all the operating staff wore clothes made of a non-woven fabric,

the numbers of bacteria fell to the level recommended for theatres where high-risk surgery is performed. Bacteria quickly migrate through wet material and certain non-woven fabrics such as Barrier Fabric 450, are impervious to water and blood.

HOSPITAL DOMESTIC MANAGEMENT

234. Cox, R. **Communication is key to hospital staff organization.** *Cleaning & Maintenance*, London, 1978, Sept., vol. 26, no. 8, pp. 22-23, 25, 27.

The domestic services department at the Royal Free Hospital, Hampstead, employs about 400 staff from many countries and the management structure is geared to give maximum supervision. Great emphasis is placed on communications and good staff relations, and owing to effective consultative machinery at all levels the hospital has remained free from recent militancy. Supervisors who are familiar with a foreign language help to explain written instructions. Staff conditions are good and a revised staff training scheme will be introduced shortly. The size of the hospital and the number of specialized areas give rise to certain cleaning problems, particularly care of the sheet vinyl floors. A sophisticated range of machinery and materials are used by small groups of cleaners who concentrate on specific areas of the hospital.

HYGIENE IN THE HOSPITAL

See Abstract No. 239

HOSPITAL INFECTIONS

235. Polakavetz, S. H., Dunne, M. E. and Cook, J. S. **Nosocomial infection: the hidden cost in health care.** *Hospitals*, Chicago, 1978, Aug. 16, vol. 52, no. 16, pp. 101-102, 104, 106.

The fact that excessive lengths of stay due to hospital infection are contributing enormously to the high cost of health care has been demonstrated in a number of studies. Ways in which the incidence of hospital infection can be reduced, thereby reducing length of stay, lowering costs and improving the quality of patient care, include: controlling the use of antibiotics; limiting unnecessary invasive procedures and reducing the risks of necessary ones; again emphasizing the use of aseptic techniques in medical education; improving personal hygiene habits; and structuring the reimbursement and regulatory system to facilitate the above practices.

PREVENTION AND CONTROL

See also Abstract Nos. 292, 293, 298

236. Bagshawe, K. D., Blowers, R. and Lidwell, O. M. **Isolating patients in hospital to control infection.** *British Medical Journal*, London, 1978, Aug. 26, vol. ii, pp. 609-613; Sept. 2, vol. ii, pp. 684-686; Sept. 9, vol. ii, pp. 744-748; Sept. 16, vol. ii, pp. 808-811; Sept. 23, vol. ii, pp. 879-881.

The virtual disappearance of many infectious diseases has not removed the need to

isolate patients. Much thought is now being given to the problems of designing and managing isolation units. It therefore seems timely to review present methods and to examine whatever evidence is available on their efficacy. The five parts of this paper cover: (i) sources and routes of infection; (ii) who should be isolated, and where; (iii) design and construction of isolation accommodation; (iv) nursing procedures; and (v) an isolation system. The system described, based on one devised for a district general hospital, uses five types of isolation: (i) standard; (ii) stool-urine-needle; (iii) strict; (iv) protective; and (v) high security.

HYGIENE IN THE OPERATING THEATRE

See Abstract Nos. 233, 254, 293

STERILIZATION

237. TURNER, T. D. **Prepack variation.** *ASSA Journal*, Matlock, 1978, Aug., vol. 7, no. 1, pp. 4-6.

A recent survey by the Surgical Dressings Research Unit, Welsh School of Pharmacy, examined three types of pre-pack systems for theatre absorbents. Approximately 60 per cent of the hospitals studied used mainly composite packs and 50 per cent mainly pre-set trays, the majority of which were treble-wrapped. Packs of both types were sealed with autoclave indicator tape. In 44 per cent of the hospitals, treble-wrapped supplementary packs were used, sealed either by heat sealing or adhesion: the opening of both systems led to a risk of contamination. Distribution and storage are important in maintaining materials in an optimum state. Sterile supplies were usually packed in plastic boxes, but transported in vehicles not used exclusively for such supplies. Storage for sterile supply items was generally adequate in central sterile supply departments but not always in the theatre suites themselves. To maintain the sterility of materials to the point of use, a third outer wrap, to be removed before entry into the theatre, should be included on all pack types.

238. CLARK, T. **The planning and equipping of a CSSD.** *Middle East Health Supply & Service*, Sutton, 1978, Aug./Sept., vol. 2, no. 8, pp. 60-62.

The concentration of all sterile supplies in one area allows for more efficient use of space, prevents staff duplication and reduces costs. Local conditions do not often permit a standardized central sterile supply department (CSSD), and all staff involved should be represented at every planning stage. A centralized organization should be used which specializes in every aspect of CSSDs. Each department should have two reception areas, one for dirty and one for clean items. The area for washing, drying and inspection of returned items needs a range of mechanical equipment and staff should wear protective clothing. Items supplied new are stored in the bulk store; the pack area should continue the smooth work flow with separate lines for goods with different destinations. Autoclaving offers the best means of sterilization, using high-speed vacuum sterilization for porous loads. Sterile items are despatched from the sterile store by means of a system of trolleys and containers. All new departments should implement a staff training programme.

SAFETY MEASURES

239. **The inspection of hospitals and health services—the approach of the Health and Safety Executive.** *Hospital Engineering*, London, 1978, Sept., vol. 32, no. 7, pp. 12-14.

A programme of basic inspections of hospitals is to be initiated by HM Inspectors of Factories and the purpose of this paper is to describe the way in which this will be undertaken. It is intended that eventually the inspection of hospitals will be fitted into the overall inspection programme covering all types of premises, but until then a special programme of inspection will be adopted. The first aim of the inspection will be to ensure that each area health authority has an adequate health and safety policy and that it has set up a management organization to implement that policy. An initial visit to the area health authority will cover the mechanics of visits to hospitals and identify the officers to be contacted. Staff representatives will also be contacted. Points covered include standards and precautions to be applied by inspectors, clinical laboratories, radiation hazards, fire precautions, inspection and the patient, and enforcement.

PLANNING FOR MASS EMERGENCIES

See also Abstract No. 274

240. WATFORD GENERAL HOSPITAL. **Major accident plan.** Watford, Watford General Hospital, 1978, [ii], 57pp. £3.00

This plan has been drawn up by Watford General Hospital to help hospital staff effectively meet the needs of a large number of injured patients should a major accident occur. An outline of the plan records arrangements made with the ambulance, fire and police services, and with other hospitals. Certain members of staff will be allocated special jobs and full instructions are given, along with the addresses and telephone numbers of staff to be contacted in such an emergency. Other information includes: location of the major accident equipment; a specimen major accident form; and a map of hospitals within the area.

RADIATION HAZARDS

241. MOULD, R. F. **Danger: guard against radiation.** *Nursing Mirror*, Sutton, 1978, Aug. 31, vol. 147, no. 9, pp. 15-18.

This article discusses protection against radiation with particular reference to nurses. Nurses will encounter most radiation hazards when dealing with radio-therapy patients. Radiation is normally confined to special treatment rooms, but when mobile X-ray equipment is used in wards or theatres, nurses must not stand too close to the machines. When nursing a radioactive patient, the time spent near the patient must be reduced by careful planning of nursing procedures. The daily time limit will depend on the gamma-ray energy and the length of half-life of the radioactive isotope being used. No time limits are required for patients who have undergone technetium imaging investigations. When solid radio-active sources are used for implants some form of lead-reinforced trolley is always required to give protection in the operating theatre.

THE PATIENT

WELFARE OF THE PATIENT

See also Abstract Nos. 251, 276

242. ZIMMERMAN, M. W. **No smoking, please!** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 183-184, 186.

In an effort to respond to the needs of its non-smoking patients, Louis A. Weiss Memorial Hospital, Chicago, established a no-smoking patient care floor. The unit selected was a 34-bed medical-surgical unit containing six single and 14 double rooms. All patients assigned to the unit are screened and are made aware that their visitors may not smoke. Staff on the unit have been most co-operative in carrying out the ban. Bright red visitors' passes and specially designed signs are used for the unit. Six months after the pilot programme was initiated, it was reviewed and a recommendation made to expand it to a second unit. The programme has been accepted enthusiastically by patients, the public and staff. The no-smoking unit has consistently had the highest occupancy rate of any medical-surgical unit in the hospital.

243. FISCHER, B., FISCHER, U. and ERHARDT, R. Gesundheitspass der LVA-Klinik Klausenbach. **['Health Pass' by the Klausenbach Clinic of the Federal German National Health Insurance Authority.]** *Öffentliche Gesundheitswesen*, Stuttgart, 1978, Oct., vol. 40, no. 10, pp. 663-667.

Newly admitted patients at a Klausenbach special hospital are required to attend, during their first week, six discussions on health matters (one per day) which are held at 6.30 a.m. The subjects covered are: stress, movement therapy, risk factors, healthy nutrition, overweight and age. At the start of the course the patient is given his 'health pass' and a stamp is affixed to it when he has participated in each discussion. When the course is completed, and the six stamps are attached to the pass, it is signed by the doctor responsible. The patient is asked to produce the pass when presenting himself for further treatment. The pass is reproduced in this paper and its objectives are discussed. The main aim is to contribute effectively to health education.

244. DRACUP, K. A. and BREU, C. S. **Using nursing research findings to meet the needs of grieving spouses.** *Nursing Research*, New York, 1978, July/Aug., vol. 27, no. 4, pp. 212-216.

This paper describes the use of nursing research findings in a coronary care setting. A standardized nursing care plan, based on Hampe's eight research-identified needs of grieving spouses, was developed by staff nurses in an intensive care unit. The 13 spouses of acutely ill patients who had received specific nursing interventions reported that more of their needs were met by nurses than did 13 on whom base-line data were collected prior to the adoption of specific nursing interventions.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See Abstract No. 277

HOSPITAL CHAPLAINS

245. LAW, M., HILL, D. and HARRIES, C. **Exploring the work of a hospital chaplain in a psychiatric hospital.** *Nursing Times*, London, 1978, Sept. 7, vol. 74, no. 36, pp. 1478-1482.

In this study of the chaplain's work at the Fulbourn and Ida Darwin Hospitals, Cambridge, the hospital staff answered questions and completed a rating scale concerning their experience of contact with the chaplain. Those who responded expressed a positive attitude, but some thought that the chaplain's role needed clarifying and that his skills could be used more fully in therapy sessions. The chaplain fulfilled the religious side of his duties with dignity, even when dealing with patients in an advanced state of mental confusion. Requests for contact with the chaplain came from both staff and patients, and their need for personal counselling was clearly being adequately met. Two tables show an analysis of the chaplain's unscheduled work, both official and personal. As a result of the study, his duties were re-scheduled to include a greater contribution to in-service training and staff discussion. In addition, moves were made to help the chaplain maintain links with the patients' former communities.

TRANSPORT OF PATIENTS

See Abstract Nos. 268, 279

TERMINAL CARE

246. BEAUCHAMP, T. L. and PERLIN, S., editors. **Ethical issues in death and dying.** Englewood Cliffs, N.J., Prentice-Hall, 1978, x, 368pp. £6.55

A collection of articles on various aspects of death and dying is presented to show the widely divergent viewpoints which exist. Aspects covered are: the definition and determination of death; suicide; the rights of the dying patient; euthanasia and natural death; and the significance of life and death. Each chapter concludes with a selected bibliography to guide the reader in further reading.

HOSPITAL CARE

See also Abstract Nos. 195, 200, 204, 206, 244, 253, 269, 270, 277, 280, 283, 299, 306, 307, 312

247. DOBSON, A. and others. **PSROs: their current status and their impact to date.** *Inquiry*, Chicago, 1978, June, vol. 15, no. 2, pp. 113-128.

This paper summarizes the 1977 evaluation of the professional services review organization (PSRO) programme conducted by the United States Department of Health, Education and Welfare. The most important conceptual outcome of the evaluation was to document and clarify conflicting views of the primary purpose of the programme. There appears to be no consensus on the issue among either policy makers or academicians. It should be noted, however, that the evaluation produced little data

to defend the view of the PSRO as a primary, cost-containment device. At the same time, quality assurance aspects of the programme were not sufficiently implemented to be fairly evaluated. Preliminary observations generated by the evaluation include: (i) PSRO represents a more costly system of hospital use review than earlier systems; (ii) medical care evaluation studies under the programme appear to be an effective means of identifying and correcting clinical and administrative deficiencies in care, but the frequency of re-audits is so far not adequate; (iii) no aggregate, statistically significant PSRO effect was found on adjusted days of care rates or adjusted admission rates; (iv) analysis of average length of stay data produced mixed results; (v) there was some evidence that case mix severity has increased in PSRO hospitals relative to matched non-PSRO hospitals; and (vi) PSROs, acting primarily on appropriateness of use, have little potential to counteract or reduce the inflation due to input prices and technology which are the major causes of the rapid rise of hospital care expenditures.

248. LUFT, H. S. **Why do HMOs seem to provide more health maintenance services?** *Milbank Memorial Fund Quarterly/Health and Society*, New York, 1978, vol. 56, no. 2, pp. 140-168.

This paper makes a comprehensive analysis of the existing literature on the use of preventive services in health maintenance organizations (HMO) and comparable populations. It is in three sections: a framework for discussion by outlining the theoretical arguments concerning the use of preventive services in various medical care settings; a discussion of the major studies of preventive use in various settings; and a demonstration of how these often conflicting studies can be understood when examined in terms of differential ambulatory coverage rather than HMO versus fee-for-services incentives. The findings suggest that, contrary to the rhetoric of health maintenance advocates, the greater use of preventive services by HMO enrollees appears to be attributable to their better financial coverage, not to the preventive care ideology.

249. VANLOH, S. W., STANGES, M. T. and COHEN, R. **Assessing the performance of hospital support services.** *Hospitals*, Chicago, 1978, Aug. 1, vol. 52, no. 15, pp. 163-164, 166.

A quality assurance programme to evaluate support services was planned, developed and implemented on a hospitalwide basis at the Veterans Administration Hospital, East Orange, N.J., in 1976. The aim was to provide a programme that was simple, easily understood, inexpensive, non-accusatory and meaningful to the services in the hospital and the administration. The Health Care Review Board (HCRB), which reports directly to a Quality Assurance Council, is responsible for the programme. Within the HCRB, a quality assurance co-ordinator was appointed to monitor and co-ordinate the programme. Heads of services were asked to submit 10 to 15 criteria to the HCRB for review. The necessary evaluation forms and control charts were developed. Volunteer evaluators (120 in all) were used to evaluate each service once a week. The evaluations were reviewed by co-ordinator, quality control charts updated, and copies of the completed and graded evaluation forms sent to the relevant service chiefs for appropriate action. After two months a meeting to review the programme decided that less frequent evaluations were necessary. The programme has received unanimous support from the entire staff and promises to be a highly effective, and practical, programme.

250. MARTIN, J. B. **Towards effective computer-aided medical care evaluation studies.** *Inquiry*, Chicago, 1978, June, vol. 15, no. 2, pp. 129-141.

The author, working in close conjunction with the medical audit committee of a 550-bed teaching hospital, developed and implemented a computerized information system to aid in the comprehensive review of the medical care provided to patients classified into six disease entities. The major emphasis was placed on developing a system that would be truly useful to medical staff rather than on the technical functioning of that system. Nine basic conclusions were reached during this research effort: (i) it is possible to develop a highly useful, retrospective criteria-based, computerized quality review system for on-going review of specific diagnostic groupings; (ii) these efforts have demonstrated that computer-assisted medical quality review has the potential to be cost-effective; (iii) the major component of direct cost in this approach to medical review lies with data collection and verification and not with actual computer manipulation; (iv) full potential cost savings from this approach will be realized only if the computer system can be implemented in a number of hospitals with minor modifications; (v) the work has demonstrated the technical feasibility of supplementing machine-readable data bases with the additional data required for comprehensive review; (vi) data linkage can be accomplished at low cost with minimum technical difficulties; (vii) very close co-operation between medical and technical staff is essential; (viii) the close co-operation has demonstrated that high levels of physician interest and input can be achieved in medical care review; and (ix) original criteria devised for a review mechanism require substantial and continuing modification.

251. LOCKER, D. and DUNT, D. **Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care.** *Social Science and Medicine*, Oxford, 1978, July, vol. 12, no. 4A, pp. 283-292.

Studies of consumer satisfaction with medical and social services are becoming an important feature of evaluation research. Consumer opinion is also important in the formulation of health care and social policy. Suggestions are made for the development of questionnaire techniques and methods of scoring satisfaction which should improve the sensitivity and comprehensiveness of measures. A method of measuring satisfaction with care environments is also suggested based on the concept of generic services. However, the basis on which consumer opinion is formulated requires further investigation in order for it to be interpreted in the context of need for care. Problems in the use of consumer opinion are examined and areas for further research identified.

HOME CARE, AFTER-CARE

See also Abstract No. 288

252. CANADA. DEPARTMENT OF NATIONAL HEALTH AND WELFARE. HEALTH CONSULTANTS DIRECTORATE. HEALTH PROGRAMS BRANCH. **Review of the literature on home care.** [Ottawa], Health and Welfare Canada, 1977, viii, 93pp.

This review of the literature on home care considers: planning and organization; home care schemes; costs of home care; programme evaluation; and home care research. Representative material from each of these areas is reviewed and the gaps in the literature outlined. Questions for further study are included, together with a list of references (pp. 88-93).

SPECIAL DEPARTMENTS

WARDS

See Abstract Nos. 178, 242

OPERATING SUITES

253 NIGHTINGALE, K. M. **Out of sight: out of mind.** *NATNews*, Matlock, 1978, Aug., vol. 15, no. 8, pp. 22-26; Sept., vol. 15, no. 9, pp. 22-26.

The project reported here grew out of a suspicion that patients are being positioned and moved in such a way that pressure injuries could develop. Two questionnaires were used to determine: the incidence of pressure damage during the patient's stay in the operating theatre with follow-up through the recovery ward and back to the patient's own ward; and whether staff were sufficiently well informed on the dangers of pressure injuries. Information was also gathered in interviews with staff. General surgery, gynaecology and orthopaedic patients were involved. It became apparent that pressure injuries did occur and were concentrated in two vulnerable areas: the heels and the lower back. There does not seem to be any factor in the patient which pre-disposes to pressure injury. The serious pressure injuries which occur post-operatively and cause distress to the patient often have a multi-factorial cause. More investigation is needed into the part played by the positioning of the patient and the use of such operating table accessories as lumber pillows, heel pads and diathermy plates.

ANAESTHESIA

254. NIELSEN, H., VASEGAARD, M. and STOKKE, D. B. **Bacterial contamination of anaesthetic gases.** *British Journal of Anaesthesia*, Basingstoke, 1978, Aug., vol. 50, no. 8, pp. 811-814.

The bacterial content of oxygen and nitrous oxide immediately before and after passing through clean and used breathing systems (circuits) was measured using a specially constructed agar chamber (Bourdillon's slit sampler). The content per litre of oxygen from the outlet of the anaesthetic machine was 4.0×10^{-2}, and 2.9×10^{-2} for nitrous oxide, corresponding to 3.5×10^{-2} for a 50 per cent mixture of the gases. After passing through cleaned circuits, the bacterial pollution of the gas mixture had increased by 30 per cent, but more than elevenfold after passing through used circuits. The content from cleaned circuits was less than that measured previously in the air of hospital wards and operating theatres, whereas gases from used circuits were polluted to approximately the same extent. It is concluded that used circuits may increase the risk of cross-infection. The cleaning method using a dishwasher and hot air drying appears to be acceptable.

PHARMACY

See Abstract No. 287

LABORATORIES

255. OTTAVIANO, P. J. and DISALVO, A. F. **Quality control in the clinical laboratory: a procedural text.** Baltimore, Md. & London, University Park Press, 1977, xiii, 223pp.

This book provides a step-by-step procedure for establishing a scheme that will meet the minimal requirements for satisfactory quality control as required by the College of American Pathologists, the Joint Commission on Accreditation of Hospitals, and the Clinical Laboratory Improvement Act of 1967. Aspects considered in the 12 chapters include: the reasons for quality control; external quality control; control of incoming materials; equipment maintenance; the basis of statistical quality control; quality control in the blood bank; clinical chemistry; haematology; medical microbiology; immunology and syphilis serology; urinalysis, and remedial action. An interim laboratory checklist is included in an appendix together with a glossary of terms and a bibliography of 32 items.

BLOOD TRANSFUSION DEPARTMENT

See also Abstract No. 173

256. WALLACE, J. **Blood transfusion for clinicians.** Edinburgh & London, Churchill Livingstone, 1977, ix, 351pp. £10.00

The aim of this book is to provide a simple yet comprehensive account of the general principles of blood transfusion in clinical practice. There are 11 chapters which consider: the spectrum of blood transfusion practice; blood products; indications for transfusion and the choice of blood products; the clinical importance of the ABO and Rh(D) groups; blood groups and the clinician; haemolytic disease in the newborn; collection and administration of blood, histocompatibility antigens and transplantation; hazards of transfusion therapy; organization of a blood transfusion service; and the future of transmission therapy.

257. POZNANSKI, W., SMITH, F. and BODLEY, F. **Implementation of a pneumatic-tube system for transport of blood specimens.** *American Journal of Clinical Pathology*, Philadelphia, 1978, Aug., vol. 70, no. 2, pp. 291-295.

Whole-blood specimens were transported through a 485 metre pneumatic-tube system used for blood transport at Ottawa Civic Hospital, Ont. Constant-speed low-carrier-velocity at 3.6 m./sec. was a feature of the system, with controlled deceleration before arrival at the destination. Inserts were padded to minimize movement during transport and landing. Results indicated that serum potassium, haemoglobin and lactate dehydrogenase activity and whole-blood pH, Pco_2, and Po_2 were not altered in freshly drawn blood transported in this system. Partial filling or heparinization of the specimen containers did not alter the results. When specimens were allowed to clot before transport by pneumatic-tube, significantly higher levels of serum lactate dehydrogenase were obtained. The study demonstrates that tube-transport of whole-blood specimens can be carried out without damage to blood components.

258. JACOBS, P. and RAWSON, W. S. **Donor recruitment and blood collection costs for Red Cross blood centers: an investigation of the economies of scale hypothesis.** *Transfusion*, Philadelphia, 1978, May/June, vol. 18, no. 3, pp. 291-297.

This paper presents a statistical analysis of the hypothesis that there are economies of scale in the collection of blood. Based on a national sample of Red Cross collection centres, an analysis was conducted to determine the relationship between total costs of obtaining blood as well as its recruitment and collection components, and explanatory factors such as local costs, mobile units used and scale of operations. Adjusting for other factors, the results indicate slight diseconomies of scale at all levels of operation: that is, as scale of operations increase, collection costs rise. When collection and recruitment costs were separated, scale and local wages were the significant explanatory variables in the former and population percentage of collection by mobile units and directed donations in the latter.

259. KAHN, R. A. and others. **The impact of converting to an all frozen blood system in a large regional blood center.** *Transfusion*, Philadelphia, 1978, May/June, vol. 18, no. 3, pp. 304-311.

The impact of converting to an all frozen blood system was studied in the Missouri—Illinois Regional Red Cross Blood Center, the sixth largest in the Red Cross system. Several basic assumptions were made including the availability of a sterile docking service which would increase the shelf life of deglycerolized blood to 72 hours. The study indicated that the most economical manner in which to implement such a programme would be to supply deglycerolized blood to all hospitals transfusing more than 500 units per year and to provide frozen units to hospitals transfusing less than this amount (those hospitals would deglycerolize the blood they use). The estimated total cost of the proposed conversion was $3.9 million or a 76 per cent increase over the present operation. Relative to the present fee structure, the average cost of a unit of blood would increase 80 per cent if only frozen or deglycerolized red blood cells were distributed.

260. BRODHEIM, E. **Regional blood center automation.** *Transfusion*, Philadelphia, 1978, May/June, vol. 18, no. 3, pp. 298-303.

The operation of an automated regional blood centre is described by following the path of a single blood unit identification number from the time it is assigned to a blood collection site to the time that the blood unit leaves the regional blood centre for a transfusion service. The approach taken to achieve the necessary degree of automation involves three concepts: (i) the use of bar codes to completely identify each blood product; (ii) the use of small, inexpensive minicomputers operated almost entirely with the use of a hand-held light pen; and (iii) the use of a modular computer design where the minicomputers are tied together into an information network via hard wire connections and/or telephone lines. The application of such a system in the Greater New York Blood Program is outlined, with particular reference to the use of a central Groupamatic blood typing facility serving four blood centres.

MILK BANKS

See Abstract No. 300

DIAGNOSTIC X-RAY DEPARTMENT

261. BUFFARD, P. and BERTHIER, J.-P. Flash fin 1976 sur la radiologie dans un grand ensemble hospitalier public. **[Review of the state of radiology in a public hospital complex to the end of 1976 [Civil Hospitals of Lyons].]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1978, Aug./Sept., vol. 33, nos. 395/396, pp. 37-43.

This is an analysis of the activity, costs, and staffing of the radiology departments in seven general hospitals, three specialist hospitals, one neurological hospital, and one cardiology hospital in Lyons, which between them provide 5,452 general beds and 777 highly specialized beds. The data are summarized in four tables. The analysis showed, among other matters, startling disparities in the number of requests for X-rays; these reflected the attidues of succeeding generations of interns and the lack of awareness among medical staff in general of the cost of X-rays. There were also disparities in the quality of work produced in different departments. Expenditure on radiology was approximately six per cent of total hospital expenditure and maintenance accounted for five per cent of this sum. There is a serious shortage of radiologists. The relative benefits of centralization and decentralization are discussed. It is suggested that the cost of paramedical staff could be reduced by employing a central relief team to cover absences of more than 10 days' duration.

262. BARTLETT, J. R. and NEIL-DWYER, G. **A clinical study of the EMI scanner: implications for provision of neuroradiological services.** *British Medical Journal*, London, 1978, Sept. 16, vol. ii, pp. 813-815.

The records of the first 571 patients to be examined by an EMI brain scanner at the Brook General Hospital, London, were studied. The patients were divided into diagnostic categories and positive and negative scans were analyzed separately. The investigations which would have been performed without the scanner being available were compared with those which were performed. The number of additional investigations required dropped significantly. The scanner is invaluable both for diagnosis and for planning treatment, but strict attention must be paid to radiographic detail. The use of a scanner in a district general hospital enables existing facilities to serve a wider population and is of particular value to patients with head injuries.

263. BARTLETT, J. R. and others. **Evaluating cost-effectiveness of diagnostic equipment: the brain scanner case.** *British Medical Journal*, London, 1978, Sept. 16, vol. ii, pp. 815-820.

Following the introduction of computerized axial tomography (CAT) scanning at the Brook General Hospital, London, a method was devised of evaluating its cost-effectiveness by: (i) assessing the demand for brain scanning; (ii) identifying other ways of meeting the demand; (iii) assessing the cost of the alternatives; and (iv) assessing the value of improved treatment. The demand was assessed by examining: (i) the demand made on the scanner; and (ii) the different types of demand made by different specialties. Five possible ways of meeting the demand and three different approaches to testing them are discussed. By using a CAT scanner the costs of consumables, maintenance and staffing can generally be reduced. In addition, less space is required and more patients can be examined as out-patients. Both on grounds of cost savings and clinical efficiency, scanners should be made more widely available.

264. BRINDLE, M. J. **Radiology work load—a solution.** *British Medical Journal*, London, 1978, Aug. 12, vol. ii, pp. 514-515.

With the commissioning of a new district general hospital, radiologists in King's Lynn are faced with an increasing workload but little prospect of extra staff. To prevent excessive workload, radiologists, through their district medical committee, should agree a 'reasonable capacity' for each department by establishing priorities and using limited facilities to the best advantage of the patients. Radiologists in King's Lynn offered to undertake 30,000 examinations (excluding ultrasound), with unrestricted service for in-patients, casualties and urgent out-patient cases, representing 70 per cent of available capacity. It was estimated that the remaining 30 per cent capacity could absorb half the current non-urgent out-patient work and a third of the demand for general practitioner work. The scheme has encountered some difficulties, but with certain modifications, it has reduced requests for examinations and decreased the radiological workload to a manageable level.

REHABILITATION

See Abstract No. 306

PHYSIOTHERAPY DEPARTMENT

265. BROWN, J. A. C. **Role of the physiotherapist in obstetrics and gynaecology.** *Physiotherapy*, London, 1978, Aug. 10, vol. 64, no. 8, pp. 228-229.

The specialist physiotherapist has a part to play in obstetrics, neo-natal paediatrics and gynaecology. The function of the physiotherapist in obstetrics is to take part, either directly or through the midwife, in the ante-natal training of the mother in rehabilitation exercises, muscle control, and breathing control during labour. Hospital based physiotherapists may be responsible in some units for respiratory problems in the neo-natal period, particularly following surgery. The physiotherapist's function in gynaecology should be to give post-operative treatment to increase the venous return and avoid thrombosis. With gynaecological out-patients the physiotherapist applies heat for pelvic inflammatory disease and has become increasingly involved with the treatment of stress incontinence.

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract No. 301

266. GLATT, M. M. **Twenty-five years of alcoholism units.** *British Journal of Alcohol and Alcoholism*, London, 1978, vol. 13, no. 1, pp. 11-20.

The author gives a brief history and outlines the function of the 22 alcoholism units in the United Kingdom, with special reference to Warlingham Park Hospital and St. Bernard's Hospital unit in Edinburgh. The former was founded in 1950 and grew quickly. Soon in-patient care was supplemented by community work and after-care. Units increased over the following years, supported by voluntary associations to help

alcoholics. It soon became clear that alcoholism should be treated by a multidisciplinary team, helped by the patient's relatives. The possibility of using the Warlingham Park Unit for education and research in the treatment of alcoholism was initiated at an early stage. All units function on similar lines offering a therapeutic community, group therapy and community follow-up, but each unit has its individual features, such as family treatment at the Cardiff Unit and the admission of patients with poor prognosis at St. Bernard's. Units also act as centres of information and advice for alcoholics, general practitioners, social workers and others. The Alcoholic Doctors' Group aims to help doctors understand the problems created by alcohol misuse.

INTENSIVE CARE UNITS

267. JONES, E. S. **Essential intensive care.** Lancaster, MTP, 1978, viii, 503pp. £9.95

The aim of this book is to indicate some aspects of general intensive care in a large district hospital. The methods used in the general intensive care unit at Whiston Hospital, Prescot, Merseyside, to investigate and treat some common emergencies are briefly described, together with the non-specific treatment which will help to restore and preserve the body fluids and metabolism. Aspects considered include: principles; respiratory failure; oxygen therapy; fluid therapy and nutrition; coronary care; microbial infections; ventilator treatment; trachaeotomy; chest injuries; renal failure; haemodialysis; peritoneal dialysis; poisonings; and measuring, recording and monitoring. Both theory and practice have been kept as simple as possible. References and bibliographies are included after each chapter.

268. HANNING, C. D. and others. **Movement of the critically ill within hospital.** *Intensive Care Medicine*, Heidelberg, 1978, July, vol. 4, no. 3, pp. 137-143.

Critically ill patients can be safely moved within hospital using a mobile intensive care unit (MICU). The MICU allows the critically ill to benefit from specialized investigation and treatment they might otherwise be denied. The MICU at the Western Infirmary, Glasgow, is a well-sprung trolley-bed mounted on castor wheels with a suction unit and metered supplies of oxygen and nitrous oxide mounted on the removable bed head. On the shelves beneath the bed are a pressure-driven ventilator, a D-C defibrillator and battery supplies. A twin-channel oscilloscope is mounted at the foot of the bed, and the electrocardiogram, body temperature and intra-arterial blood pressure are displayed continuously. There is also a case containing a range of drugs, intubation equipment, intravenous apparatus and cannulas. The merits of the MICU are outlined in the light of clinical experience gained over a 12-month period.

269. TOMLIN, P. J. **Intensive care—a medical audit.** *Anaesthesia*, Oxford, 1978, Sept., vol. 33, no. 8, pp. 710-715.

The intensive care unit of Queen Elizabeth Hospital, Birmingham, is a six-bedded unit serving a 620-bed teaching hospital. The hospital has two other special units, for renal dialysis and coronary care. This paper describes an audit of the unit covering a four-year period between 1972 and 1976 during which time 1,718 patients were admitted. It shows that allocating one per cent of all acute beds for intensive care purposes is not

adequate. This is reflected by the high mortality among the patients discharged from the unit. Sophisticated monitoring equipment led to a marked improvement in mortality rates in each group to which it was applied. Simple to use, automated, biochemical equipment was very cost effective for blood gas measurement but less so for electrolyte determinations. Intensive care is very labour intensive, but the cost benefit in terms of lives saved is large. It is suggested that audits of this type help to identify the consequences, of decisions by administrators.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

270. O'NEAL, E. A. **A framework for ambulatory care evaluation.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, July, vol. 8, no. 7, pp. 15-20.

A framework is presented that will help ambulatory care nursing departments to participate in the development of patient care evaluation programmes. The framework identifies the unique aspects of ambulatory patient care and the deficiencies of the present system. It emphasizes the interrelatedness and interdependence of the three components of ambulatory care (medical records/data systems, patients/providers, and patient-care delivery systems) and suggests an interdisciplinary team approach to patient care. The need for careful definition of the nursing role in the ambulatory setting is emphasized.

CASUALTY AND ACCIDENT

See also Abstract Nos. 278, 307

271. LONDON, P. S. **Accident services.** *British Journal of Hospital Medicine*, London, 1978, Aug., vol. 20, no. 2, pp. 169-170, 172-173, 177.

This paper concentrates on changes that have occurred in accident services in Great Britain since 1970. The first part deals with hospital services, where the accident and emergency consultant has been introduced and new training programmes established. But the casualty services remain understaffed and not the most popular departments of hospitals. Four points are offered as the basis for constructive proposals to remedy the situation: (i) casualty departments are understaffed at all levels and this is one reason why they are unpopular with junior staff; (ii) they deal with a large number of the ills and hurts that patients suffer from; (iii) there is little available information about the work done by casualty departments in general; and (iv) emergency care must be dealt with and therefore 'cold' cases accumulate on ever-increasing waiting lists. If these propositions are accepted, the following solutions are offered: (i) medical, surgical and other firms on emergency duty at any one time should provide some staff in the casualty department; (ii) there is still a place for the casualty consultant and the pure casualty officer; (iii) the casualty consultant with beds has an important part to play in the smaller hospital; (iv) in the larger hospitals there is a place for the accident surgeon who will work, teach and organize in an accident department; and (v) special training programmes will be needed. The second part deals with services outside the hospital and covers first aid and the voluntary societies, ambulance services, general practitioners and disasters.

272. MULLNER, R. and GOLDBERG, J. **Toward an outcome-oriented medical geography: an evaluation of the Illinois trauma/emergency medical services system.** *Social Science & Medicine*, Oxford, 1978, June, vol. 12, no. 2D, pp. 103-110.

An evaluation of the Illinois Trauma/Emergency Medical Services System is presented as an example of outcome-oriented medical geography. A sample of vehicular injuries and deaths are compared for a four-year study period covering the two years before system implementation (1970-71) and two years after system initiation (1972-1973). This analysis reveals three failures in the scheme: (i) there was no increase in the number of critically injured vehicular trauma victims treated at trauma centres; (ii) distances that patients travelled to care remained relatively constant after system implementation; and (iii) the size of the hospital service area did not conform to the guidelines of the scheme. In spite of these factors the Illinois Trauma/Emergency System is considered a success because of the decreases in mortality rates which were experienced at Trauma Hospitals in 1972 and 1973; mortality rates at those hospitals which did not become trauma centres remained constant.

273. ELLIOTT, M. J. and VAYDA, E. **Characteristics of emergency department users.** *Canadian Journal of Public Health*, Ottawa, 1978, May/June, vol. 69, no. 3, pp. 233-238.

Percentages of the residents of North Hamilton, Ontario, using the local Hamilton General Hospital emergency department and those using St. Joseph's Hospital, one mile south, were compared. At the Hamilton General Hospital, 35 per cent of the 1,260 visits made over a period of three weeks were made by North Hamilton residents. At St. Joseph's Hospital, North Hamilton residents made up 17 per cent of the visits studied. The groups of users were divided into urgent and non-urgent emergency cases. Males, Protestants, native-born Canadians and recent residents were over-represented at both hospitals when compared with the total population of the area. Higher social classes and single people were under-represented at the local hospital. Younger people of recent residence were over-represented at both hospitals. There were more older, married people using the Hamilton General Hospital: the majority of cases were non-urgent, but many had suffered trauma. A study of this kind shows that emergency department use is more closely linked with socio-demographic factors than with a specific catchment area.

274. SNOOK, R. **Medical care at accidents and disasters.** *Injury*, Bristol, 1978, Aug., vol. 10, no. 1, pp. 14-21.

For social, economic and humanitarian reasons, it seems logical to apply technology to the intensive care of the accident victim. Intensive care need not be confined to special units of a large hospital; it is rather a concept of intermediate intervention that can equally be applied at the scene of the accident. To provide such a service requires efficient organization and communication, whether the service is a hospital cardiac arrest team, a hospital accident flying squad, a general practitioner immediate care team or a major accident team. There are two principal requirements of an emergency 'call-out' system: rapid activation of the system and immediate alerting of the individual. An essential feature of a successful immediate care team is its relationships with fire, police and ambulance services. More and improved equipment, and training in its use is necessary To put theory into practice, equipment should be broken down into sets

of 'individual' size, special protective clothing for the chemical incident should be provided and a small mobile unit capable of carrying the equipment to the small, medium or large incident should be designed. Included in the paper are plans of a major accident ambulance and educational unit, a major accident plan in diagrammatic form, and an ambulance information form.

275. GOSNOLD, J. K. **The violent patient in the accident and emergency department.** *Royal Society of Health Journal*, London, 1978, Aug., vol. 98, no. 4, pp. 189-190, 198.

Concern has been expressed about the management of violence in accident and emergency departments in the Department of Health and Social Security Circular HC(76)11 and the Confederation of Health Service Employees' publication 'The management of violent or potentially violent patients'. The staff of accident and emergency departments are usually untrained in the management of violence and the design of the department is often poor. Early diagnosis of the condition causing violence is important and every effort should be made to obtain information concerning the patient's medical background. The following should be looked for: (i) drug abuse; (ii) alcoholism; (iii) psychiatric illness; and (iv) medical illness. The approach to the patient should be confident and the minimum restraint possible should be used to control violence. A social worker with mental health qualifications should be attached to every accident and emergency department. There has been a large increase in compensation paid to staff in recent years, and a concentrated effort needs to be made to change staffing levels and the design of departments.

DAY HOSPITALS

See Abstract Nos. 289, 294, 302

INFECTIOUS DISEASES AND ISOLATION

See Abstract No. 236

CHILDREN

See also Abstract No. 288

276. LATIMER, E. **Play is everybody's business in the children's ward.** *Nursing Mirror*, Sutton, 1978, Sept. 14, vol. 147, no. 11, pp. 21-24.

This article describes the play-scheme which has been developing at The Hospital for Sick Children, Great Ormond Street, since the establishment of a play co-ordinator in 1971. The role of the nursery nurses has been changed to emphasize their part in play and there are now three trained full-time and two part-time play leaders. Nurses are expected to gain some practical experience of children's play on the ward or in the play-centre to enable them to work well with the play-staff. Voluntary workers and parents are also very helpful. Each 20-bedded unit has its own playroom, and 13 of these are now covered by play-staff, who provide a variety of activities. The play-centre is well equipped and has an indoor and outdoor play space. A nursery nurse provides

play material daily in the out-patient department. There is a hospital school to cater for the needs of the over-fives and on four evenings a week there are supervised activities for older children. Equipment and materials for the play-scheme is provided by the Friends of the Children of Great Ormond Street.

277. REYNOLDS, D. **Getting better with a new granny.** *Community Care*, Sutton, 1978, Aug. 16, no. 226, pp. 16-18.

The scheme of giving a child in hospital a volunteer 'granny' was first thought of five years ago. However, although the scheme is active in some hospitals, such as King's College and St. Charles', London, it has expanded very little, since it is not always possible to find a suitable woman with time to spare. Nurses do not always understand the importance of the granny scheme and care must be taken to foster a good relationship between the real and the adoptive parent. Ideally, grannies should look after one child full-time, be given some financial recognition and be supported by the nurses and social workers. The scheme is not easy to operate, but, if properly thought out and supported, it has an important part to play in the welfare of the child in hospital.

278. MADDOCKS, G. B., SIBERT, J. R. and BROWN, B. M. **A four-week study of accidents to children in South Glamorgan.** *Public Health*, London, 1978, July, vol. 92, no. 4, pp. 171-176.

Children under 16 who sought hospital treatment in South Glamorgan as a result of accidental injury were studied during a four-week period in 1976. A total of 1,442 children attended, 60.6 per cent of whom were boys, representing a yearly total of 17 per cent of the children in the area. In general, younger children injured themselves at home and older children outdoors or at school. Falls were a common course of injury (43.3 per cent), but the percentage of children hurt in traffic accidents was low (1.8 per cent). Minor treatment or reassurance was all that was needed by 75 per cent of the children, and only eight per cent were admitted to hospital.

279. JOHNSON, M. A., OWERS, J. and HORWOOD, S. P. **Air transport of infants in Newfoundland and Labrador.** *Canadian Medical Association Journal*, Ottawa, 1978, July 22, vol. 119, no. 2, pp. 127-134.

In some areas of North America where surface transportation is either unavailable or slow, air transportation is now being used. Information on the transport of infants to and from Charles S. Curtis Memorial Hospital, St. Antony, Newfoundland, by aircraft was gathered over a two-year period from March 1975 to April 1977. The air transportation of 33 infants in small, unpressurized aircraft over long distances is described. Twenty-six of the infants were transported more than 320 km. in environmental temperatures ranging from −35° to +21°C. The practical problems of inadequate oxygenation of infants at 3,000 m. in unpressurized aircraft can be difficult, since cold and vibrations can affect equipment and at high altitudes the readings from oxygen analysers may not be true. However, safe and efficient air transport of infants is possible provided that: (i) the equipment ensures a stable thermal environment and adequate oxygenation; (ii) the escort and other members of the expanded transport team understand the equipment and the requirements of the sick newborn; and (iii) the trip is adequately planned with consideration of the problems of noise, vibration, lack of space, high altitudes and environmental temperatures.

GERIATRICS AND LONG-STAY

See also Abstract No. 225

280. NURSING TIMES. **The elderly: a challenge to nursing.** Basingstoke, Macmillan Journals, 1978, 51pp. £1.25

This collection of 18 papers reprinted from the Nursing Times, considers all aspects of geriatric care. The series of papers is comprehensive in scope although not in depth and investigates how demographic, physiological, psychological and environmental factors impinge on the care which nurses give to old people. References are included after each paper.

281. BROCKLEHURST, J. C. and others. **Medical screening of old people accepted for residential care.** *Lancet*, London, 1978, July 15, vol. ii, pp. 141-142.

Medical screening for 100 old people at the time of their acceptance for admission to residential (part 3) care revealed a large amount of previously unreported yet treatable illness. As a result of screening, alternative care was thought more appropriate in 32 cases—hospital admission in 16, sheltered housing in four, and remaining at home in 12. It is suggested that the most appropriate time for medical screening is when an old person moves from independent to institutional living.

282. GRASSL, E. Altenhilfe und Altenarbeit für die Zukunft. **[Future aspects of old-age care and aid.]** *Öffentliche Gesundheitswesen*, Stuttgart, 1978, Sept., vol. 40, no. 9, pp. 603-610.

As a result of the increase by approximately 30 per cent in the number of people over 75 in the Federal Republic of Germany, it is expected that for the period 1975 to 1990, between 50,000 and 60,000 nursing beds will be required for a total of five per cent of patients in need of special care. Consequently, hospitals will have to be expanded and nursing homes altered into nursing wards. Those people who are physically fit should not be admitted to nursing homes. There should be an efficient overall old-age service offering food delivery, laundry services and nursing care; the services could be provided by volunteers and by social welfare institutions. The need for establishing good links between aged people and society is discussed.

283. ANDREWS, J. and ATKINSON, L. **Selecting equipment for elderly patients in hospital.** *British Medical Journal*, London, 1978, Aug. 12, vol. ii, pp. 484-486.

Three categories of ward furniture and equipment essential on geriatric wards are considered: (i) equipment needed during acute illness; (ii) equipment needed during rehabilitation; and (iii) equipment for continuing care departments. All beds should be height-adjustable and sometimes anti-pressure sore beds are required, such as the three-sectioned bed, the water bed or the low-air-bed. Other items needed include anti-pressure sore devices, safety sides and bed cradles. The types of chairs needed in a rehabilitation ward must be carefully considered and there are several specific ones for specific uses. Adaptations to fit baths and toilets are available to suit many levels of handicap. The Association of Disabled Aids Manufacturers could well be used to improve co-operation between the designers of equipment and the hospital staff who

use it. Departments of geriatric medicine should systematically evaluate the equipment available. A detailed list of all items mentioned is given.

284. SCHICKE, R. K. **A methodology in surveying geriatric patients, facilities and services.** *Social Science and Medicine*, Oxford, 1978, July, vol. 12, no. 4A, pp. 229-234.

This study considers the methodology used for surveying long-term patients, geriatric facilities and their services, with implications for planning improved services for the aged in New Jersey. A two-fold enquiry was carried out to assess patient characteristics reflecting service needs; and the data relating to the services themselves. A comparison of the social and medical needs of the elderly with the services required to meet those needs provides valuable information for planning purposes.

285. TURNER, R. J. and STERNBERG, M. P. **Psychosocial factors in elderly patients admitted to a psychiatric hospital.** *Age and Ageing*, London, 1978, Aug., vol. 7, no. 3, pp. 171-177.

Over a three-year period, 204 consecutive patients admitted to Barrow Hospital, Bristol, a psychiatric unit for the elderly, were studied, and their progress followed for a further two years. For three-quarters of the patients it was their first ever admission to such a unit. More than half were suffering from a functional psychiatric disorder. Of the patients, 27.9 per cent were discharged to their own homes, 31.9 per cent discharged into care, and 35.3 per cent died, while 17.6 per cent were admitted on at least one further occasion. Unfavourable outcome was associated with males over 75 with organic psychiatric disorders. Favourable outcome was associated with those under 75, who were married and had a functional psychiatric disorder. Females with psychiatric depression were frequently re-admitted. From the data obtained in the survey, the elderly appear to be remarkably resilient and able to work through the crises which have brought about their admission.

CANCER

286. **Against a subtle enemy.** *Nursing Mirror*, Sutton, 1978, Aug. 31, vol. 147, no. 9, supplement pp. i, iii, v, vii-ix, xi, xiii.

These five articles form an introduction to the first International Conference on Cancer Nursing, held at the Royal Marsden Hospital in September 1978. In the first article, the Director of Nursing at the Royal Marsden emphasizes that cancer nursing is not specialized in itself, but requires total patient care, planned to cater for the individual patient. The Royal Marsden uses a variety of clinical nurse specialists in the care of cancer patients. The second article describes the work of the Sutton branch of the Royal Marsden, including radiotherapy treatments, the paediatric unit and a ward reserved for barrier nursing. The third article outlines the recent achievements and present aims of cancer research. The fourth article discusses the eight continuing care units built on hospital sites for terminal patients by the National Society for Cancer Relief. The final article gives some views expressed by the Patients' Association regarding cancer treatment where prognosis is poor. Details are also given of the courses on oncological nursing offered by the Joint Board of Clinical Nursing Studies.

287. BERRY, R. J. and BRYAN, G. **Dare we count the cost of cancer chemotherapy?** *Lancet*, London, 1978, Sept. 2, vol. ii, pp. 516-518.

During 1972-1976 when the incidence of cancer rose only slightly in the United Kingdom and the number of patients seen at a large metropolitan teaching hospital with special interests in cancer remained largely unchanged, the use of cytotoxic drugs rose from 5.1 per cent to 14 per cent of the hospitals' total drug budget. Most of the rise in cost can be ascribed to the increased use and increased unit cost of four effective but expensive drugs. It is argued that cytotoxic chemotherapy cannot offer a 'cheap alternative' to surgery and radiotherapy. In a health service with cash spending limits, the use of the more expensive cytotoxic drugs should be limited to the treatment of patients in whom 'cure' or long-term ablation of disease is being attempted, or to protocol studies in which their effectiveness is compared with that of other, possibly less expensive, drugs. Further studies are required of the use of the less expensive cytotoxic drugs in order to maximize their usefulness in the palliative treatment of advanced disease.

288. MARTINSON, M. I. and others. **Home care for children dying of cancer.** *Paediatrics*, Evanston, 1978, July, vol. 62, no. 1, pp. 106-113.

The preliminary findings from a research project dealing with home care of children with cancer are reported. The project involved 32 families with children up to 17 years of age who were dying of cancer and for whom no treatment requiring a hospital stay was planned. Each family was assigned and introduced to a primary nurse who had the major responsibility for the home care and a backup nurse for when the primary nurse was not available. The results of the project are presented, together with one detailed case study. Results to date indicate that allowing children with terminal cancer to die at home rather than in hospital is clearly feasible. No insurmountable obstacles appeared, although to work effectively home care required some role changes. Although the overall cost savings would be great, the cost to the parents would be increased if home care were not included in their insurance cover. Even in this case, cost is unlikely to be a major consideration.

289. PIETROIUSTI, M., LONGONI, F. and GIUNTA, R. Il day hospital oncologico. **[The cancer day hospital.]** *Ospedale*, Torino, 1978, Aug./Sept., vol. 31, no. 8/9, pp. 203-210.

The concept, purpose, and functions of a day hospital are explained and the organization and structures of the day hospital for the National Tumour Institute in Milan, which is now at the planning stage, are described.

NEUROLOGY AND NEUROSURGERY

See Abstract Nos. 262, 263

CARDIOLOGY

See Abstract No. 295

VENEREAL DISEASE

290. BHANJI, S. and MAHONY, J. D. H. **The value of a psychiatric service within the venereal disease clinic.** *British Journal of Venereal Diseases*, London, 1978, Aug., vol. 54, no. 4, pp. 266-268.

A significant proportion of attenders at venereal diseases clinics can be regarded as potential psychiatric patients, yet few clinics have a psychiatrist in regular attendance. A study was carried out over a three-month period at the Alexanda Clinic, St. Giles Hospital, London, to determine whether there was a useful role for a psychiatrist in a clinic and to delineate common areas of concern. Twenty-two patients were referred for psychiatric assessment; of the 20 who kept their appointment 18 were diagnosed as mentally ill or as having a personality disorder. The major sources of common venereological and psychiatric concern appeared to be among the promiscuous and the hypochondriacal patients. The former consisted of people with personality disorders who were thought unlikely to respond to psychiatric treatment; but some of the latter improved with pimozide. The results of a questionnaire indicated that staff considered there was an important place for a psychiatrist within their clinic.

SURGERY

291. CARSTAIRS, V., WATKINS, G. and YOUNG, D. **The use of surgical beds: variations between consultants in duration of stay for selected operations.** *Health Bulletin*, Edinburgh, 1978, July, vol. 36, no. 4, pp. 162-169.

This paper examines variations between consultants in Scotland in the average lengths of stay of patients for eight named operations. For operations involving both sexes there was no marked difference according to sex, but for all operations the length of stay increased significantly with the age of the patient. Mean stays tended to be longer in non-teaching than in teaching hospitals, and the range of mean stays was greater. The post-operative stay tended to be longer in non-teaching hospitals, except for mastectomies and hysterectomies. There were positive links between pre- and post-operative stays, and the lengths of stay tended to lessen as the number of patients increased. Between 1965 and 1975 the total mean stay for all the eight operations fell by two days. Although lengths of stay have lessened overall, the wide variations in mean stay suggest that the duration of stay in some cases could be shortened still further. Detailed results of the study are shown in a number of tables.

292. WESTABY, S. and EVERETT, W. G. **A wound irrigation device.** *Lancet*, London, 1978, Sept. 2, vol. ii, pp. 503-504.

The wound irrigation device described was designed to aid the nursing of patients with post-operative wound infection and dehiscence. A rim of stomahesive is fixed into a transparent plastic cover, which has exit and entry ports for the supply of irrigating fluid and the escape of the fluid and wounds exudate. Three precautions aid successful use: (i) the bond between stomahesive and the skin may be improved by adding 'micropore'; (ii) the patient should lie quietly for two or three hours after application; and (iii) irrigation should be delayed for four hours. Material for examination may be

obtained from the drainage bag or from swabs applied through the exit port. The device may remain in place until the wound is clean and non-offensive.

293. McLaughlan, J., Scotland, A. D. and Trexler, P. C. **Sterile micro-environment for post-operative wound care.** *Lancet*, London, 1978, Sept. 2, vol. ii, p. 503.

The Vickers Medical wound isolator provides a small area free of bacteria to isolate the wound post-operatively. It consists of a flexible plastic polyvinyl chloride dome welded to an adhesive surgical drape: this drape forms the base of an envelope and is placed round the wound. Cones in the envelope form access points for sterile air supply, wound drainage, and suction. The isolator is supplied pre-packed and gamma irradiated and is applied in the theatre. A controlled trial of the isolator versus a standard dressing is in progress and extensive bacteriological monitoring within the isolator has already proved that the sterility of the air is maintained.

294. Garraway, W. M., Ruckley, C. V. and Prescott, R. J. **General practitioners' response to day care surgery.** *Practitioner*, London, 1978, July, vol. 221, no. 1321, pp. 22, 23, 25.

The reaction of general practitioners to day care surgery was assessed in a 26-month study of 498 patients in Edinburgh who had undergone day surgery for varicose veins or hernia. A total of 163 general practitioners were asked to comment on various aspects of day surgery. A high proportion thought it had more advantages than disadvantages for themselves, the patient and those attending the patient. Practitioners qualified for 20 years or less, especially those with postgraduate qualifications, emphasized the importance to themselves of increased involvement in the post-operative care of their patients. The size of the practice did not influence opinions, but the presence, or absence, of district nursing staff did. Thus, the response of the general practitioner to day care surgery would appear to be favourable.

295. McGregor, M. and Pelletier, G. **Planning of specialized health facilities: size vs. cost and effectiveness in heart surgery.** *New England Journal of Medicine*, Boston, Mass., 1978, July 27, vol. 299, no. 4, pp. 179-181.

An attempt was made in Montreal to compare the costs of open-heart surgery in a specialized heart institute with those in a smaller teaching hospital, assuming the same length of stay and the same nursing costs for both hospitals. Costs were divided into those which are the same regardless of turnover and those which vary according to turnover. An average for each type of cost at each hospital was calculated. The cost per operation was then related to the number of operations performed each year. The cost is very high in any hospital carrying out under 50 operations per annum and a turnover of at least 100 operations is required to produce even a slight financial advantage. The cost of cardiac catheterization and coronary angiography fell when turnover rose to about 400 studies a year. It is generally accepted that adequate turnover is essential to maintain the skills needed for complex surgery. In general, the ideal turnover would appear to be about 150 operations a year and about 500 catheterization studies.

MATERNITY

See also Abstract No. 265

296. CHAMBERLAIN, G. **A re-examination of antenatal care.** *Journal of the Royal Society of Medicine*, London, 1978, Sept., vol. 71, no. 9, pp. 662-668.

Ante-natal surveillance aims to: (i) diagnose and treat abnormalities; and (ii) detect asymptomatic diseases. Patients who attend for ante-natal care generally have a lower perinatal mortality rate. The first ante-natal visit, when a medical history is taken and a thorough clinical examination is given, is most important in the detection of any possible problems. A blood sample is taken to establish the patient's ABO and rhesus group and to estimate haemoglobin. In large centres, plasma is often checked for alphafeto-protein. A large number of patients now receive ultrasound measurements to help estimate the gestation of the foetus. The urine is checked for protein and sugar at all visits. Throughout the pregnancy, patients are requested to return at intervals which become shorter as the obstetric needs increase. An assessment needs to be made to distinguish those ante-natal procedures which are of little value from those which should be more widely introduced.

297. O'BRIEN, M. **Home and hospital: a comparison of the experiences of mothers having home and hospital confinements.** *Journal of the Royal College of General Practitioners*, London, 1978, Aug., vol. 28, no. 193, pp. 460-466.

A study was carried out between September and December 1975 on the feelings, attitudes and preferences of women having home and hospital confinements. The study was drawn from a sample of 100 women over 24 registration districts in England and Wales, chosen with probability proportional to the number of births. The response rate (90.9 per cent) was not significantly different between those who gave birth at home and those who gave birth in hospital. Births in institutions accounted for 95.5 per cent of all births in the sample, similar to the proportion in the population. The findings revealed that labour lasted a shorter time at home; fewer women were left alone at home; and there were fewer episiotomies at home. Seventy-six per cent of husbands were present at the birth at home compared with 30 per cent in hospital. The factors suggest that more needs to be done to improve the qualitative aspects of delivery in hospital and to provide greater relationships within the patient's family.

298. CORSINI, V., COLAPIETRA, F. and LA PAGLIA, S. Il problema del controllo delle gestanti e della trasmissione delle salmonelle col parto: risultati di 24 mesi di osservazione. **[Transmission of Salmonella in childbirth: results of 24 months study.]** *Ospedale*, Torino, 1978, Aug./Sept., vol. 31, no. 8/9, pp. 211-213.

The bacteriological tests used in Este Provincial Hospital to check expectant mothers for the presence of Salmonella are described. Over a two-year period, nine cultures positive for Salmonella were obtained from among 1,410 mothers, and during the same period four positive cultures were obtained from among 1,426 newborn infants born to these mothers. In two cases the Salmonella was shown to have been transmitted from mother to child, and in the third case, transmission from case No. 2, in the nursery at the same period, was proved. The source of the fourth case is not known.

299. RICCARDI, V. M., COHEN, A. and CHEN, M. T. **Genetic counseling as part of hospital care.** *American Journal of Public Health*, Washington, D.C., 1978, July, vol. 68, no. 7, pp. 652-655.

A four-year retrospective chart survey of representative in-patient admission to Milwaukee Children's Hospital, Wisc., was carried out to determine whether genetic counselling was part of routine in-patient care. The charts of a sample of 478 patients with any of 10 specified types of genetic or congenital disorders were studied to document whether the receiving of genetic counselling had been given. The disorders were of four types: chromosomal, single gene, polygenic and those characterized by multiple congenital anomalies, with or without a syndrome designation. Although 4.2 per cent of the hospital's patients had one of the 10 disorders, in the same charts studied genetic counselling was given five times, and 'offered' only twice. The authors suggest that under utilization of genetic knowledge and resources may be partly remedied by incorporating a formal genetic disposition into hospital discharge methods.

300. MCENERY, G. and CHATTOPADHYAY, B. **Human milk bank in a district general hospital.** *British Medical Journal*, London, 1978, Sept. 16, vol. ii, pp. 794-796.

A human milk bank has been organized in the special care baby unit at Whipps Cross Hospital, London. The staff of the unit and members of a voluntary organization help to contact donors from both within and outside the hospital and arrange the collection of samples. From 1975 to 1978, 2,093 samples of expressed breast milk were collected from 187 donors and were examined bacteriologically. Of these, 1,171 grew no bacteria and most of the samples with organisms were cleared by mild heat treatment. Sixty-five babies received milk from the bank during its second year and were not adversely affected. The cost of establishing and running a milk bank need not be high. The co-operation and goodwill existing between the hospital staff, volunteers and donors contributed greatly to the scheme's success.

301. BARLOW, B., COLGAN, A. and COX, J. **The work of the obstetric physiotherapist.** *Physiotherapy*, London, 1978, Aug. 10, vol. 64, no. 8, pp. 229-230.

Obstetric physiotherapy has gradually, but steadily, improved in recent years. The physiotherapist can help to create a friendly and informative atmosphere at ante-natal classes, where she can teach controlled breathing, muscular control to cope with postural changes and relaxation techniques to reduce fatigue. Many mothers who do not attend ante-natal classes need extra attention in the post-natal period regarding abdominal control and restoration of the pelvic floor muscles. The physiotherapist may also be asked to deal with post-operative complications involving the use of infra-red and ultra-violet light and ultrasound.

GYNAECOLOGY

See Abstract No. 265

PSYCHIATRY

See also Abstract Nos. 168, 189, 245, 266, 275, 285, 290

302. FINK, E. B., LONGABAUGH, R. and STOUT, R. **The paradoxical underutilization of partial hospitalization.** *American Journal of Psychiatry*, Washington, D.C., 1978, June, vol. 135, no. 6, pp. 713-716.

Partial hospitalization continues to be underused even though its clinical effectiveness for a variety of psychiatric patients has been demonstrated. The authors investigated the potential economic advantage of partial hospitalization by comparing matched groups of day hospital patients and in-patients who had comparable symptoms and prognoses on admission. They present one-year's follow-up data documenting the comparability of the study groups on clinical outcome measures and the cost advantages favouring the partial hospitalization group. Possible causes of the paradoxical underuse of the clinically effective and lower-cost partial hospitalization are discussed; they include institutional factors, patients' clinical characteristics, family resistance, and clinician bias.

303. MACKAY, J. La modernisation d'un hôpital psychiatrique traditionnel. **[Modernization of a traditional psychiatric hospital in Montreal.]** *Bulletin de l'Union Mondiale pour la Sauvegarde de l'Enfance et de l'Adolescence*, Paris, 1978, July/Sept., no. 57, pp. 3-9.

The author assesses the results of the modernization programme embarked on five years ago at Rivière-des-Prairies Hospital, Montreal. The programme was based on the allocation of one care team to each of seven subsectors, each team to take complete charge of a sectorized population which included out-patients, day patients, and in-patients. Because of their numbers, their chronic condition, and the severity of their handicaps, the in-patients posed all the problems associated with institutionalization in an 'asylum'. To-day there are, on average, 630 patients instead of the original 850. There are 200 admissions per annum, and only 290 of the original patients are still in the hospital; 340 are in hostels. There has been a slight overall reduction in staff numbers but an increase in the numbers of qualified staff. The most difficult objective to achieve was desegregation of the in-patients and the elimination of the section for the severely handicapped. The author believes that this would have been impossible if one team had not been responsible for all the patients in its sector and had been able to send its most difficult clients elsewhere.

304. LEWIS, B. R. and others. **Measuring the public image of psychiatric hospitals: is it a significant cause of recruitment problems?** *Comprehensive Psychiatry*, New York, 1978, May/June, vol. 9, no. 3, pp. 257-265.

One of the major concerns of the administrators of a large British psychiatric hospital was their apparent inability to recruit an adequate number of ancillary staff. Furthermore, although the hospital was currently employing as large a nursing staff as budget constraints allowed, there was some doubt as to whether the right kind of people were being employed as nurses and nursing assistants. A questionnaire was devised to determine an individual's view of psychiatric hospitals covering mental health prejudice, and knowledge and perceptions of the hospital environment. A quota

sample (based on age and sex) of 199 adults were interviewed in the West Midlands and Lancashire. Little prejudice was expressed, less than expected, but gaps in knowledge were evident. In addition, respondents did not perceive the hospital environment in a good light. Contrary to initial speculation, the public image of a psychiatric hospital appeared not to be a significant factor in deterring potential job applications but prejudice regarding mental health was. However, mental health prejudice is not a very pronounced phenomenon, and 57 per cent of working respondents said they would consider applying for a vacancy if it matched their own personal job aspirations and requirements. The implications of the findings for recruitment are discussed.

305. MULLER, D. J. **The external provision of health maintenance organization mental health services.** *American Journal of Psychiatry*, Washington, D.C., 1978, June, vol. 135, no. 6, pp. 735-738.

Three ways in which mental health services may be provided in a health maintenance organization (HMO) are described: by an internal department of psychiatry; by one or more unrelated external autonomous care providers; or by an external autonomous group of providers. It is proposed that the latter type is the better model, offering many of the advantages of the internal department while delivering more personalized, higher care at lower cost to the HMO. However, certain conditions must exist, including convenient location, regular conferences with other HMO physicians, and the provision of educational and preventive services, if the superiority of this model is to be maintained.

306. HAUSNER, C. and others. Rehabilitationstraining mit mehrjährig hospitalisierten Patienten. **[Rehabilitation training with chronic mental patients.]** *Psychiatrische Praxis*, Stuttgart, 1978, Aug., vol. 5, no. 3, pp. 179-187.

In a half-way house for chronic mental patients in West Germany a rehabilitation training scheme was carried out for chronic schizophrenics who had been in hospital for 12 years on average. The situations a patient would be confronted with outside the hospital and which would require social competence to deal with them were evaluated. Behaviour therapy and social reinforcement altered the patients' behaviour significantly. A general plan for diagnosing and evaluating social competency is outlined. This plan can be used to restructure the training of the staff in educational-therapeutic behaviour as well as the training of the patients themselves.

307. DAVIES, J. **Violence in the general hospital: the management of violent or potentially violent patients.** *Royal Society of Health Journal*, London, 1978, Aug., vol. 98, no. 4, pp. 187-188.

The Confederation of Health Service Employees (COHSE) has recently issued a publication called 'The management of violent or potentially violent patients'. It points out the legal dangers to hospital staff when dealing with violence and the Department of Health and Social Security is conducting a review of the legal situation. The problem of violence is increasing in casualty departments of general hospitals and the staff are not trained to deal with it. In many cases, porters have to help with difficult situations and it is not easy to obtain a psychiatric bed in an emergency. Similar problems arise for ambulance staff, ancillary hospital staff and community clinic staff. The COHSE report recommends that: (i) the law be clarified regarding:

(a) consent to treatment with regard to informal psychiatric patients and (b) the right to search patients; (ii) better provision be made for psychiatric patients in casualty departments; and (iii) the question of training to deal with violence be considered.

308. SIMON, G. B. **Meeting the needs of mental disorder—for the mentally handicapped.** *Health and Hygiene*, London, 1978, April/June, vol. 1, no. 4, pp. 197-200.

Some problems of the present provision for the mentally handicapped in Great Britain are outlined. The basic requirements which must be provided in every district are well documented; they include district assessment centres, counselling for parents at the time when the diagnosis of mental handicap is made, and assistance to parents in the management of their children. For a population of some 60,000 to 120,000 depending on the area covered, a team is required consisting of a specialist nurse and specialist social worker, with an input from the paediatrician, the specialist in mental handicap and any other professional whose advice will be required from time to time. A base for the team should be provided in a community unit in existing health service or local authority premises. It should provide facilities for day care with programming and training and some residential care for immediate, on demand, short-stay care. More specialized facilities should be provided on an area or even regional basis.

309. SYMONS, J. **Health service provision for mentally handicapped people.** *Design for Special Needs*, London, 1978, Jan./April, no. 15, pp. 22-26.

This discussion of existing provision for the mentally handicapped is based on visits to: Lightwood House, Sheffield; the Gloucester Centre, Peterborough; Ridge Hill, Dudley; South Ockendon Hospital; Honeylands, Exeter; the Old Rectory, King's Worthy; and Field End House, Islington. A plan and two photographs are included.

310. FELCE, D. and others. **Comments of the Health Care Evaluation Research Team on the report by the Development Team on Services for the mentally handicapped in Hampshire.** (Report No. 136) Winchester, Health Care Evaluation Research Team, 1978, 2 vols.

The background to the Development Team's report is briefly outlined, and is followed by 11 appendices giving the comments of the Health Care Evaluation Team. Various errors, omissions and inconsistencies are pointed out concerning: discharge of patients; locally-based hospital units and hospital 'annexes'; benefit to patients from locally-based units; 'community units'; and statements from the Mental Handicap Register. The Development Team's report also failed to take account of the views expressed by staff and relatives of children in hostels. Volume 2 consists of an Appendix covering the pattern of residential services for mentally handicapped people in Hampshire: implications of the current Wessex strategic policy and of implementing the recommendations made by the Development Team.

311. **A caring architecture for the mentally handicapped.** *RIBA Journal*, London, 1978, Sept., vol. 85, no. 9, pp. 369-374.

This feature presents the experience of one architectural practice in designing accommodation for the mentally disturbed and handicapped. The facilities briefly

described are: (i) Lightwood House, Norton, Sheffield, a 96-place unit for mentally handicapped adults with day care facilities for up to 11; (ii) a research project to design a unit similar to Lightwood House, on a smaller site; and (iii) regional secure units at Friern Hospital and Balderton Hospital, near Newark. Plans and photographs are included.

312. CURRY, J. B. and PEPPE, K. K. **Mental retardation: nursing approaches to care.** St. Louis, C.V. Mosby, 1978, xii, 246pp. £7.15

Some of the efforts and contributions of nurses in the provision of care to the mentally handicapped and their families are documented. Part one provides the background, outlining the historical development of mental handicap nursing and the present status and needs in nursing education. Part two discusses several frameworks for nursing practice, and part three deals with various aspects of nursing approaches to care, namely: prevention; identification and assessment of the handicapped child; and intervention techniques.

AUTHOR INDEX

Andrews, J. 283
Atkinson, L. 283
Austin, C. J. 210
Australia. Hospital and Health Services Commission 163
Bagshawe, K. D. 236
Banaszak, S. M. 179
Barlow, B. 301
Bartlett, J. R. 262, 263
Beauchamp, T. L. 246
Bergmann, R. L. 165
Berry, R. J. 287
Bethe, M. 176
Berthier, J.-P. 261
Bhanji, S. 290
Blowers, R. 236
Bodley, F. 257
Boreham, N. C. 195
Boyd, K. 188
Breu, C. S. 244
Brindle, M. J. 264
Brocklehurst, J. C. 281
Brodheim, E. 260
Brook, P. 189
Brook, R. H. 206
Brown, B. M. 278
Brown, J. A. C. 265
Brunet-Jailly, J. 198
Bryan, G. 287
Buffard, P. 261
Canada. Department of National Health and Welfare. Health Consultants Directorate 252
Carstairs, V. 291
Chamberlain, G. 296
Chattopadhyay, B. 300
Chen, M. T. 299
Clark, T. 238
Cohen, A. 299
Cohen, R. 249
Colapietra, F. 298
Colgan, A. 301
Contis, J.-P. 180
Cook, J. S. 235
Corsini, V. 298
Cox, J. 301
Cox, R. 234
Curry, J. B. 312
Daneels, F. 224
Davidson, S. M. 220
Davies, J. 307
Deland, E. C. 186
Dewulf, J. 224
DiSalvo, A. F. 255
Diseker, R. A. 202
Dobson, A. 247
Dracup, K. A. 244
Dredge, D. S. 169
Dunne, M. E. 235
Dunt, D. 251
Durocher, J. 227, 228
Elliott, M. J. 273
Ellis, B. 201
Erhardt, R. 243
Errahmani, E. 160, 161
Everett, W. G. 292
Fee, T. 226
Felge, D. 310
Fink, E. B. 302
Fischer, B. 243
Fischer, U. 243
Frenzen, P. D. 165
Friedman, E. 200
Garraway, W. M. 295
Gassilloud, B. 159
Gecser, O. 170
Giunta, R. 289
Glatt, M. M. 266
Goldberg, J. 272
Gosnold, J. K. 275
Grassl, E. 283
Greene, B. R. 211
Griffiths, D. 174
Grosvenor, P. 190
Günther, O. 162
Hall, C. P. 205
Hanning, C. D. 268
Harries, C. 245
Harris, R. J. 213
Hausner, C. 306
Hayden, R. L. 192
Hays, P. G. 217
Hill, D. 245
Hollingsworth, A. T. 177
Horner, S. O. 177
Horwood, S. P. 279
Howitt, L. F. 184
Hubbard, J. P. 185
Illuminating Engineering Society of North America 172
Jacobs, M. O. 197
Jacobs, P. 258
Johnson, M. A. 279
Jones, E. S. 267
Kahn, R. A. 259
Keaveny, T. J. 192
Kensett, R. G. 175
Kessler, M. S. 165
Kingsdale, J. M. 204
Krug, F. T. 171
La Paglia, S. 298
Lamy, P. P. 218
Larochelle, Y. 232
Latimer, E. 276
Law, M. 245
Levine, J. I. 191
Lewis, B. R. 304
Lidwell, O. M. 236
Lively, C. A. 199
Locker, D. 251
London, P. S. 271
Longabaugh, R. 302
Longoni, F. 289
Luft, H. S. 248
McEnery, G. 301
MacGillivray, B. 157
McGregor, M. 295
Mackay, J. 303
McLaughlan, J. 293
Maddocks, G. B. 278
Magee, C. C. 222
Mahony, J. D. H. 290
Maloney, J. V. 186
Martin, J. B. 250
Martinson, M. I. 288
Mitchell, N. J. 233
Mobley, W. H. 177
Montegriffo, C. 158
Moore, F. I. 193
Moss, T. J. 186
Mould, R. F. 241
Muller, D. J. 305
Mullner, R. 272
Neil-Dwyer, G. 262
Nielsen, H. 254
Nightingale, K. M. 253
Nursing Times 280
O'Brien, M. 297
O'Neal, E. A. 270
Osmolski, R. J. 222
Ottaviano, P. J. 255
Owers, J. 279
Palmer, G. R. 182
Pelletier, G. 295
Peppe, K. K. 312
Perlin, S. 246
Perry, S. E. 194
Pietroiusti, M. 289
Polakavetz, S. H. 235
Potvin-Rousseau, R. 230
Poznanski, W. 257
Prescott, R. J. 294
Raphaelson, A. H. 205
Rawson, W. S. 258
Raymond, D. 229
Rees, L. T. 207
Reynolds, D. 277
Riccardi, V. M. 299
Riendeau, N. 231
Riggs, F. L. 171
Rode, E. A. 208
Rodgers, A. M. 169
Roffe, B. D. 218
Rogatz, P. 216

Rolph, J. E. 206
Roy-Choudhury, S. 183
Ruckley, C. V. 294
Salmon, B. L. 223
Schicke, R. K. 284
Schroeder, S. A. 219
Scotland, A. D. 293
Shaffert, T. K. 212
Shearer, A. 168
Sibert, J. R. 278
Silver, D. F. 170
Simon, G. B. 309
Singleton, E. K. 193
Sluyter, C. K. 217
Smith, F. 257
Smith, H. 187
Snook, R. 274
Soós, L. 178
Stanges, M. T. 249
Sternberg, M. P. 285
Stimmel, B. 187
Stokke, D. B. 254
Stout, R. 303
Symons, J. 310
Tomlin, P. J. 269
Trexler, P. C. 294
Tudge, C. 214
Turner, R. J. 285
Turner, T. D. 237
United States. Health Resources Administration 209
Unklesbay, K. 225
Unklesbay, N. 225
Vanloh, S. W. 249
Vasegaard, M. 254
Vayda, E. 273
Verhaegen, W. 224
Wallace, J. 256
Wallace, S. D. 166
Warner, K. E. 203
Watford General Hospital 240
Watkins, G. 291
Watteau, J. P. 196
Weaver, D. K. 173
Westaby, S. 292
While, A. E. 156
Wilford, N. B. 215
William, K. N. 206
Willner, R. F. 179
Woodward, A. 221
Young, D. 291
Zimmerman, M. W. 242

Addresses of publications referred to in this issue

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ASSA Journal, Sherwood House, Matlock, Derbyshire DE4 3LT, England.
Administration Hospitalière et Sociale, 4237 Rue de Bordeaux, Montreal, Canada. $2.50
Age and Ageing, Ballière Tindall, 35 Red Lion Square, London WC1R 4SG. £4.50
American Journal of Clinical Pathology, East Washington Sq., Philadelphia, Pa. 19105, U.S.A. $5.00
American Journal of Psychiatry, 1700 18th St. N.W., Washington, D.C. 20009, U.S.A.
American Journal of Public Health, 1015 Eighteenth St. N.W. Washington, D.C. 20036, U.S.A. $3.00
Anaesthesia, Blackwell Scientific Publications, Osney Mead, Oxford OX2 0EL, England.
Annals of Internal Medicine, 4200 Pine St., Philadelphia, Pa. 19104, U.S.A.
British Journal of Alcohol and Alcoholism, B. Edsall & Co. Ltd., 36 Eccleston Sq., London SW1.
British Journal of Anaesthesia, Macmillan Journals Ltd., 4 Little Essex St., London WC2R 3LF.
British Journal of Hospital Medicine, Northwood House, 93-99 Goswell Road, London EC1V 7QA.
British Journal of Venereal Diseases, B.M.A. House, Tavistock Sq., London WC1H 9JR.
British Medical Journal, British Medical Association, Tavistock Sq., London WC1H 9JR.
Canadian Journal of Public Health, 1335 Carling Ave., Suite 210, Ottawa, Ont. K1Z 8N8, Canada. $3.00
Cleaning and Maintenance, 902 High Road, London N12 9SB.
Community Care, International Publishing Corp., Surrey House, 1 Throwley Way, Sutton, Surrey SM1 4QQ, England. £0.20
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Food Technology, 221 N. Lasalle, Chicago, Ill. 60611, U.S.A.
Gestions Hospitalières, 2 rue Jules-Verne, 78200 Mantes-la-Jolie, France. 35F.
Health Bulletin, Scottish Home and Health Department, Trinity Park House, South Trinity Road, Edinburgh EH5 3SF, Scotland. £0.40
Health and Hygiene, Royal Institute of Public Health and Hygiene, 28 Portland Place, London W1N 4DE.
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Inquiry, 840 North Lake Shore Drive, Chicago, Ill. 60611, U.S.A. $5.00
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